toward racial minorities in the LGBT communities; interracial dating is often understood to be proof of such lack of bias toward LGBT people of color.)

Gender and sexuality are also complex categories through which LGBT people understand their experiences. Although no reductionist approach should be used to juxtapose Whites’ and people of color’s experiences with these categories, it is important to mention how terms such as *two-spirited*, *same-gender loving*, *family*, and *de ambiente* (Spanish for “from the crowd”) are used by various communities of color to identify their behavior, attraction, or belonging to an LGBT community (or to a community at large but with some specific recognition). Lesbians and lesbians of color are particularly affected by the erasure of gender and gendered experiences within studies of LGBT communities because much funding, attention, and literature respond to male-identified individuals who are members of LGBT communities—more so when speaking of African American or Latino men. Lesbians also experience a set of erasures when their sexuality is highlighted; commonalities between them and heterosexual and bisexual women concerning harassment, experiencing sexism and developing tools to respond to it, and histories of abuse and trauma tend not to be foregrounded.

In sum, LGBT communities comprise a variety of experiences. LGBT identities are often framed through the lens of whiteness even when seldom noticed. LGBT people of color experience additional barriers toward social acceptance in society. And although LGBT is used as a coalitional term, it does not mean that all communities are represented equally—or treated equally—within such coalition movements.

*Salvador Vidal-Ortiz*

See also Civil Rights Movement; Discrimination; Immigrant Communities; Immigration, U.S.; Machismo; People of Color; Privilege; Sexuality

Further Readings


**Life Expectancy**

Life expectancy, broadly defined as the number of years an individual can expect to live, is widely regarded as one of the most powerful indicators of the overall health of a society as well as the health of specific subpopulations within a society. In the United States today, Blacks have a significantly lower life expectancy than do their White, Asian, and Hispanic counterparts, with Blacks living roughly 7 fewer years than Whites. This gap is due largely to Blacks’ high infant mortality rate, which is more than twice that of Whites. Multiple factors contribute to race disparities in life expectancy, including socioeconomic resources, lifestyle and health behaviors, social environment, and access to and quality of health care services. This entry describes the methods used to calculate life expectancy and document racial differences in life expectancy throughout the 20th and 21st centuries in the United States. It describes the social factors that influence life expectancy and reviews current debates about the relative strengths of these purported influences. Finally, it discusses ways in which policies and public health practices may help to close the race gap in life expectancy.

**Defining Life Expectancy**

*Life expectancy* is a statistical projection of the length of an individual’s life. Specifically, it is an estimate of
the average number of additional years a person can expect to live if the age-specific death rates for a given year prevail for the rest of his or her life. It is a hypothetical measure because it is based on current death rates, yet actual death rates change over the course of a person’s life. Consequently, each person’s life expectancy changes as he or she ages. Demographers typically calculate two different life expectancy measures: (a) life expectancy at birth, or the number of years a new baby born in a given year can expect to live, and (b) one’s life expectancy at age \( n \), or the number of additional years an individual who is \( n \) years old can expect to live.

Life expectancy at birth does not simply equal life expectancy at age \( n \) plus \( n \) years because age-specific life expectancy is selective. That is, individuals who have survived the potentially dangerous years of infancy and childhood are more likely to have an extended life span than is the average member of their birth cohort. For example, life expectancy at birth for a given cohort may be 75 years, yet 75-year-olds in that birth cohort probably can expect to live another 10 years. Life expectancy at birth is lower than life expectancy at 75 years of age because it includes in its calculations those babies who went on to die during infancy, adolescence, or young adulthood. These young ages at death reduce the average life span for members of that birth cohort.

Life expectancies vary widely across nations and within nations by race, ethnicity, and social class. In developing nations, high infant mortality rates contribute to low life expectancies. For instance, life expectancy at birth in Malawi was approximately 46 years in 2006. In contrast, life expectancy at birth in Japan topped 80 years. In addition, life expectancy is affected heavily by “crisis” mortalities that affect large numbers of young persons such as wars and epidemics. For example, life expectancies in many sub-Saharan African nations during the early 21st century range from 35 to 40 years, reflecting high rates of AIDS in nations such as Botswana and Swaziland and reflecting warfare in Sierra Leone and Angola.

### Race Differences in Life Expectancy in the United States

In the United States today, the leading causes of death for Blacks and Whites are similar. The top three causes of death (heart disease, cancer, and stroke) and seven of the ten leading causes of death are the same for both groups (Table 1). However, Blacks generally die younger than do Whites, and the racial gap in mortality has widened during the past 2 decades. According to the National Center for Health Statistics, White women outlive Black women by roughly 5 years, with life expectancies at

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause of Death</th>
<th>Percentage</th>
<th>Cause of Death</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Non-Hispanic Blacks</td>
<td></td>
<td>Non-Hispanic Whites</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Heart disease</td>
<td>26.8</td>
<td>Heart disease</td>
<td>29.2</td>
</tr>
<tr>
<td>2</td>
<td>Cancer</td>
<td>21.6</td>
<td>Cancer</td>
<td>23.1</td>
</tr>
<tr>
<td>3</td>
<td>Stroke</td>
<td>6.5</td>
<td>Stroke</td>
<td>6.7</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes</td>
<td>4.4</td>
<td>Chronic lower respiratory disease</td>
<td>5.7</td>
</tr>
<tr>
<td>5</td>
<td>Unintentional injury</td>
<td>4.3</td>
<td>Unintentional injury</td>
<td>4.1</td>
</tr>
<tr>
<td>6</td>
<td>Homicide</td>
<td>2.8</td>
<td>Influenza and pneumonia</td>
<td>2.8</td>
</tr>
<tr>
<td>7</td>
<td>Chronic lower respiratory disease</td>
<td>2.7</td>
<td>Alzheimer's disease</td>
<td>2.7</td>
</tr>
<tr>
<td>8</td>
<td>HIV/AIDS</td>
<td>2.7</td>
<td>Diabetes</td>
<td>2.6</td>
</tr>
<tr>
<td>9</td>
<td>Nephritis</td>
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<td>1.5</td>
</tr>
<tr>
<td>10</td>
<td>Septicemia</td>
<td>2.1</td>
<td>Suicide</td>
<td>1.3</td>
</tr>
<tr>
<td></td>
<td>All others</td>
<td>23.5</td>
<td>All others</td>
<td>20.2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
<td></td>
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</tr>
</tbody>
</table>

birth of 80.3 and 75.6 years, respectively (Figure 1). For men, the gap is even more pronounced; in 2003, White men’s life expectancy at birth was 75.3 years as compared with just 69.0 years for Black men. During the first half of the 20th century, all U.S. residents experienced tremendous gains in life expectancy and the race gap nearly halved from 15 to 8 years between 1900 and 1950. The gap narrowed again during the 1970s and 1980s, yet it has widened over the past 2 decades.

The narrowing disparity during the 1970s and 1980s is attributed to four factors. First, racial differences in smoking declined during that time. Second, Blacks experienced a large reduction in the prevalence of hypertension, especially among men. Third, with the passage of Medicare and Medicaid programs in 1965, Blacks gained greater access to health care. Finally, racial differences in income declined slightly during the 1970s and early 1980s; however, progress has since stalled and, in some cases, reversed. A 2005 study by former U.S. Surgeon General David Satcher found that the racial gap in mortality increased during the late 1980s and 1990s for infants and for men age 35 years or older. This retrenchment is due largely to the AIDS epidemic and deaths from violence (particularly homicides related to drugs), both of which increased during the 1990s.

**Infant and Late-Life Mortality**

A further analysis of the race gap in mortality reveals that it is most pronounced at the beginning of life, particularly during infancy. The gap narrows, and actually reverses according to some scholars, during old age. Infant mortality rates can be calculated in three ways. First, overall infant mortality rates refer to the number of deaths of infants under 1 year old per 1,000 live births during a given year. Second, neonatal mortality rates reflect deaths of infants under 28 days old per 1,000 live births. Third, postneonatal mortality refers to deaths of infants between 28 days and 1 year of age per 1,000 live births. Regardless of the measure used, Black infant mortality rates are roughly twice those of Whites today, whereas White, Asian, and Hispanic rates are roughly comparable. Native American rates are slightly higher than those of Whites yet lower than those of Blacks.

Perhaps the most disheartening pattern is that the race gap in infant mortality has remained large and stable for the past 5 decades. Figure 2 shows infant mortality rates by race and Hispanic ethnicity from 1940 to 2003 (rates for Hispanics were first calculated in 1985). Although infant mortality rates were nearly halved between 1940 and 1950, dropping from 74 to 43 for Blacks and from 43 to 27 for Whites, the racial gap has narrowed only slightly. The high infant mortality rate among Blacks in the United States is the single largest contributor to the overall life expectancy gap and also contributes to the fact that the United States is currently ranked 28th worldwide in its infant mortality rate.

Infant deaths are due primarily to congenital abnormalities, preterm or low birth weights, sudden infant death syndrome (SIDS), problems related to pregnancy complications, and respiratory distress syndrome. However, each of these risk factors affects infants born into ethnic minority families far more than those born into White families, with Blacks being the most severely affected. Maternal health behaviors such as smoking, substance use, poor nutrition, lack of or delay in receiving prenatal care, medical problems, and chronic illness (particularly maternal diabetes) have been cited as the primary contributors to the high infant mortality rates in the Black community.

Although Blacks are disadvantaged relative to Whites during infancy and adulthood, some demographers argue that the race gap in life expectancy...
actually reverses among the “oldest-old” (persons age 85 years or older). To date, evidence for the “race crossover” effect is equivocal. Some propose that Blacks who have managed to withstand and survive the environmental stresses of their younger years may have a survival advantage or “hardiness” that destines them to live especially long lives. However, others counter that the apparent crossover reflects age over-reporting among older Blacks, for whom advanced age is a source of pride and respect.

Unpacking the Race Gap in Life Expectancy

Racial/ethnic differences in life expectancy are not unique to the United States. Among countries with reliable data, demographers have documented that in the early 21st century, Whites have a higher life expectancy than do First Nations people in Canada, whereas Parsis in India and Jews in Israel have higher life expectancies than do members of minority ethnic groups. Policy-makers and practitioners must recognize the specific sources of mortality differentials if they hope to develop effective strategies for reducing such gaps. Four explanations are widely accepted for these discrepancies in the United States and elsewhere: socioeconomic factors (e.g., education, employment stability, job quality, income), lifestyle and health behaviors (e.g., nutrition, physical activity, diet, smoking, substance use), social environment (e.g., neighborhood and work conditions, discrimination, social integration, stress), and access to and quality of health care services (e.g., quality of local hospitals and clinics, treatment by health care professionals, access to early screening and vaccinations). On each of these dimensions, Blacks are disadvantaged relative to Whites in the United States, and these disparities in social and personal resources contribute to the life expectancy gap.

Scholars disagree, however, about the relative importance of these influences. Although social epidemiologists emphasize socioeconomic resources as a powerful influence on life span, some researchers point to the “Hispanic paradox” as evidence that economic disadvantage does not necessarily portend a shortened life span. Hispanics, like Blacks, have lower levels of education and income than do Whites, yet they enjoy life expectancies and infant mortality rates on a par with those of Whites. This pattern is attributed, in part, to the hardiness of Hispanics—particularly Mexicans—who migrate to the United States, but it is also attributed to the healthy diets, greater reliance on breast-feeding infants, low levels of smoking and drinking, and extensive social networks and strong family ties maintained by recent Mexican immigrants. Adherents to the Hispanic paradox perspective focus on targeting health behaviors as a strategy for reducing the race gap in life expectancy.

Experts also disagree about the influence of genetics. Although some racial/ethnic groups have a heightened risk of specific illnesses, such as sickle-cell anemia among African Americans and Tay-Sachs disease among Ashkenazi Jews, social scientists generally believe that such illnesses are not pervasive enough to explain overall racial differences in life expectancy. During recent years, many scholars have turned their attention away from individual-level risk factors, such as health behaviors and genetics, and instead have focused on social relationships that influence health and, ultimately, mortality. Recent research documents that racial discrimination is associated with elevated blood pressure, whereas neighborhood characteristics, including the availability of goods and services and the social integration and stability of neighborhoods, affect the health, health behaviors, and mortality of the residents.

Policymakers also increasingly recognize the role of community, socioeconomic resources, and access
Healthy People 2010, a policy statement developed by the U.S. Department of Health and Human Services, has as its top two objectives “to increase quality and years of healthy life” and “to eliminate health disparities.” The strategies proposed for achieving these aims encompass “improving health, education, housing, labor, justice, transportation, agriculture, and the environment.” Ultimately, the elimination of economic and social disparities on the basis of race may be the most effective way to alleviate racial disparities in health and longevity.

Deborah Carr and Alena Singleton

See also African Americans; Discrimination; Health Disparities; HIV/AIDS; Social Inequality

Further Readings


LINCOLN, ABRAHAM (1809–1865)

Abraham Lincoln was the 16th president of the United States (1861–1865). Previously, he had been in the Illinois legislature (1834–1842) and the U.S. House of Representatives (1847–1849). He was an unsuccessful U.S. Senate candidate in 1855 and 1858, losing the latter race to Stephen A. Douglas.

Views on Slavery

Lincoln’s views on slavery were consistent but complex. His father had moved the family from Kentucky to Indiana partly to avoid association with slave society. During his 20s, Lincoln transported goods on a flatboat to New Orleans, where he observed the slave markets and reportedly expressed revulsion at slavery. As a member of the Illinois legislature, he refused to sign a resolution condemning abolitionists for encouraging slave revolts; he endorsed another resolution that, although critical of abolitionists, noted that the system of slavery was founded on injustice and bad policy. Yet in his early public career, Lincoln did not give prominence to the issue. In speeches such as the 1838 Lyceum Address and the 1842 Temperance Society Address, he referred to slavery only elliptically and by analogy. As a lawyer, he defended a master seeking to reclaim a fugitive slave as well as a fugitive claiming his freedom.

Lincoln’s antislavery convictions were aroused by the passage of the Kansas–Nebraska Act of 1854. Until then, he said, public opinion was that the founders had placed slavery on the path to extinction. So long as that was the case, its continued existence could be tolerated as a matter of necessity. But the Kansas–Nebraska Act opened the possibility of perpetual slavery. Lincoln made opposition to slavery’s extension the centerpiece of his political creed, and it became the organizing principle of the new Republican Party. He believed that slavery must either expand or die, so containing it would be the first step toward its demise. He considered this to be a conservative position, returning to the approach of the founders.

For Lincoln, the fundamental evil of slavery was that it denied slaves the fruits of their labor, and secondarily, it was inconsistent with self-government. To the argument that slaves in the South were treated better than wage earners in the North, he responded that slavery precluded upward mobility, whereas northern wage earners might become self-employed merchants or capitalists. He defended the right to strike on the grounds that one retained control over one’s labor. Frequently, he maintained that any system holding that one person was entitled to rule another person placed liberty for all at risk. Lincoln was not insensitive to the