MOVING AND GROOVING: ACTIVITY BENEFITS OF SOCIAL INTEGRATION MAY DEPEND ON RELATIONSHIP QUALITY

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New evidence indicates that being more socially integrated increases physical and leisure activities (Fingerman et al., 2019), thus reducing the health risks of being sedentary. Yet socially integrated individuals often have both positive (e.g., supportive) and ambivalent (e.g., supportive and conflictual) relationships. The current study investigated whether the two kinds of relationships exhibit comparable associations with activity levels, and in turn, health. In-person interviews conducted with a national sample of adults ages 65 to 91 (N = 916) assessed participants’ social ties, frequency of vigorous physical activity and leisure activities, and functional health limitations. Hierarchical multiple regression analyses structured to test mediation were conducted. Having more social ties (both positive and ambivalent) was associated with more frequent physical and leisure activity. After adjusting for demographic characteristics, both kinds of social ties were related to health limitations, albeit in opposite directions, with positive ties related to fewer limitations and ambivalent ties related to more limitations. Once physical and leisure activities were included, the association between positive ties and health limitations became nonsignificant, whereas the adverse effect of ambivalent ties remained unchanged. These findings reveal that the health benefits of positive, but not ambivalent, social ties may be explained by physical and leisure activities. This ability to get people up and moving has, until recently, been an overlooked benefit of social integration. Further investigation of the quality of social ties will extend knowledge of the pathways by which they affect health.

THE EFFECT OF FINANCIAL DIFFICULTIES ON COGNITIVE FUNCTION IN A JAPANESE ELDERLY POPULATION SAMPLE

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Background: Studies have been investigating the effect of financial difficulties on cognitive function especially in the US and Australia. However, there is still a discrepancy regarding the results. This study aims to estimate the effect of financial difficulties on cognitive function in a Japanese elderly population sample. It is rewarding to focus on the Japanese setting, which has the highest proportion of elderly in the world.

Method: This study uses a longitudinal panel dataset which include randomly selected elderly Japanese citizens aged 60 and over; the National Survey of the Japanese Elderly. It is a panel dataset containing income and cognitive function. It is ideal dataset to capture the probability of onset of cognitive impairment as it focuses on the elderly. We estimate the effect of participants’ equivalent income on the probability of onset of cognitive impairment at a following survey point using random-effect probit model. Result: The first main result is there is a significant negative effect from financial difficulties on cognitive function. The results indicate that when participants’ equivalent income drops by 1%, they are 2.2% more likely to develop cognitive impairment. The second result is that this negative effect is heterogeneous, depending on their income level. Specifically, this negative effect is observed only at low income level, but not at high income level. That is, the deteriorating effect by impoverishment would be severe when the financially needy people faced income drops. Discussion: Income support plays an important role in improving recipients’ cognitive function, especially among the poor.

SOCIOECONOMIC STATUS AND THE GENDER GAPS IN LATE AGE SELF-REPORTED HEALTH IN TAIWAN

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The socio-economic status (SES) are the fundamental causes of gendered health disparity. However, how the gender gap in self-reported health (SRH) mediate by SES at old age over time is still unresolved. Some argue the SES measures play more and more important role to explain the gender gap in SRH at later age because the feminization of poverty and female’s longer widowhood increased the gap over life course through cumulative disadvantage approach. But others SES-SRH gradients in gender gap keep convergent by age since the effects of SES on health for male has declined and make the gender gap in health disparity vanish over time. Our results show for every age, increasing SES is associated with declining risk of reporting poor health and the effects can explain much more for women than men, especially for the older old below age 70. The effects of SES and marriage on the magnitude of the gender gap are substantial approximately 40 percent among seventy year olds to the full gender gap among 55-64 year olds in 2006.

GENDER INFLUENCES ON LIFE SPACE TRAVEL AMONG THE OLD-OLD

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This paper focuses on gender influences on life space mobility based on distance from home traveled by elderly retirees. Consideration of life space travel offers a window into environmental autonomy and complexity in late life. The gendered nature of time use and social networks have been primarily studied in younger age groups. Our sample included 437 older adults (mean age 83 for both men and women) living in a large Florida retirement community that offered no services. Mean age was 83 for both men and women. Fewer (37.6%) women than men (69.7%) were married and more men drove a car (83% vs 63%). Women reported poorer subjective health and had more IADL limitations. Compared to women, men were significantly more likely to travel long distances. Women’s weekly and monthly travel tended to be local, limited to their neighborhood. On average, respondents of both genders visited their families and friends out of town every month. Better health, current driving and volunteering were related to longer driving distances for both genders, but these advantages were no longer significant after controlling for demographic characteristics. Our findings underscore the complex relationships between gender and life space travel in late life. Even among elderly...
men and women of the same age better health and driving resources contribute to larger life space for elderly men.

EDUCATION, LITERACY, NUMERACY AND HEALTH INFORMATION SEEKING IN LATER LIFE
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Health information plays a critical role for health promotion and maintenance in later life. While health information seeking is primarily driven by need (e.g., health), significantly less is known about the roles of education and health-literacy. Thus, we examine complex pathways that link health information seeking behaviors with education and health literacy (decomposed into general literacy and numeracy), and how these pathways differ by health status among a nationally representative sample of Americans age 50 and older (n = 2,750). Data come from the 2012/2014 Program for International Assessment of Adult Competencies. Multi-group structural equation models were used to examine the use of eight health information sources (newspapers, magazines, internet, radio, TV, books, friends/family, and health professionals) by health status (good vs. poor). Findings showed that literacy and numeracy are significant mediators of the relationship between education and health professional as an information source. Additionally, the mediation effects on health professionals by literacy status [indirect-effect (good vs. poor health) = 0.48 vs. 2.13, p < 0.05] and numeracy [indirect-effect (good vs. poor health) = -0.47 vs. -1.81, p < 0.05] were significantly moderated by health. At the same time, no moderated mediation effect was observed in the use of any other information sources. This study provides some of the first nationally representative evidence regarding how education functions through health literacy components to shape health information seeking behaviors by health status. Explanations and implications for differing effects of education, literacy, and numeracy on health information seeking in later life were evaluated.

RACE, BIOLOGICAL AGE, AND COGNITION: THE SYSTEMATIC ASSESSMENT OF GERIATRIC ELEMENTS IN ATRIAL FIBRILLATION STUDY
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Atrial Fibrillation (AF) is associated with dementia and cognitive decline. AF is less prevalent among Blacks than Whites, although AF-related complications are more common in Blacks. In the general population, all-cause cognitive decline and dementia are more prevalent among Blacks than Whites. Thus, studying diverse populations with AF may advance our understanding of racial disparities in cognitive functioning. We created a measure of multisystem dysregulation (weathering), which includes but is more encompassing than aging, and examined its association with racial differences in cognition using data from the SAGE-AF study, a prospective cohort of >65-year olds with AF, at high stroke risk, and eligible for anticoagulation. Biological (as opposed to chronological) age among 974 participants was calculated using the Klerma and Doubl method using biomarkers representing physiological functioning, metabolism, and blood pressure. We defined weathering as the difference between biological and chronological age (weathering >0 indicates that biological age is higher than chronological age). We measured the association between weathering and the Montreal Cognitive Assessment (MoCA) score. Mean weathering (SD) was -0.7 (11.5) and 4.3 (12.6) for whites and non-whites, respectively. There was an interaction between race/ethnicity and weathering on cognition (P=0.004). In stratified analyses, higher weathering was associated with a lower MoCA score among both Whites and non-Whites but more so among non-whites (B = -0.09, 95% CI: -0.17, -0.02) for Whites (B = -0.03, 95% CI: -0.06, -0.01) for non-whites. Aging-related multisystem dysregulation is more strongly associated with worse cognition in non-whites than in whites.

THE EDUCATION-HEALTH GRADIENT AND PATHWAYS TO MORTALITY
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Large and widening educational gaps in life expectancy exist in the United States, but the mechanisms behind the education-health gradient are not well understood. We aim to study the different pathways of mortality by education group and decompose the life expectancy gap at age 50 into three components: differences in initial health at age 50, differences in transition rates to poor health states, and differences in mortality rates, given the health state. We use 11 waves of the Health and Retirement Survey and model the evolution of mortality, and health states (measured by self-rated health, limitation on any activity of daily living, and ever diagnosed with a range of health conditions). We estimate Markov models of transitions between health states and mortality over two year periods and use these transition matrices to simulate how a cohort’s health changes as they age. We find a 6-year gap in life expectancy between the highest and lowest education groups. Initial health states account for one-third of the gap in life expectancy, primarily from differences in objective health measures. The gap has widened over time, explained by comparatively better health status changes for the higher educated group, compared to the other education groups. The lower education groups have high rates of transition to poor health states, but not differential mortality rates conditional on their health state. These results suggest that educational gaps in life expectancy are due to the onset of ill health at earlier ages, and not different mortality outcomes after disease diagnoses.

ASSOCIATIONS OF GENETICS AND LIFE COURSE CIRCUMSTANCES WITH A NOVEL AGING MEASURE THAT CAPTURES MORTALITY RISK
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A novel measure of aging based on health trajectories was developed using a large nationally representative sample of older adults and was tested for associations with genetics and life course circumstances. The measure captures mortality risk and captures mortality risk possibly due to differential health trajectories across genetic groups. These associations suggest that genetic factors may influence the life course circumstances that influence health trajectories.