Worldwide trends in health risks, lifestyle behaviors, health perceptions, and health-seeking patterns suggest alarming disparities among individuals from low- and middle-income countries; particularly for older individuals (≥ 60 years). This study aims to compare health risks, perceptions, lifestyle behaviors, and health-seeking patterns between younger (< 60 years) and older (≥ 60 years) Filipinos from rural communities in the Philippines; and assess relationships between demographic, health risks and perceptions, and lifestyle behaviors to bolster health promotion efforts. A comparative cross-sectional study was employed with 863 younger and 427 older Filipinos. Results show that older participants were more likely to be single/widowed and had ≤ high school education. Older participants had higher rates of hypertension, dyslipidemia, diabetes, and depression but were more likely to report higher quality of life, ≥ 150 minutes of physical activity per week, ≥ 5 servings of fruits and vegetable per day, more difficulty falling asleep, report seeing a physician regularly, going to the community health center when sick, and attend stress management classes compared to their younger counterparts (all p's < .001). There were no differences in rates of obesity, self-medication, and use of integrative health. Older age was associated with higher risks, improved health perceptions, healthier lifestyle behaviors, and better health-seeking patterns. Our data suggest that health risks are higher in older individuals but risky lifestyle behaviors were higher in younger individuals and suggest the need to design separate health promotion interventions that target the unique needs of older and younger Filipinos from rural communities.

IMMIGRATION-RELATED FACTORS AND DEPRESSION HELP-SEEKING AMONG OLDER CHINESE AMERICANS

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Asian Americans have the lowest mental health service utilization rate among all racial/ethnic groups. One important yet understudied aspect of this group's mental health service use is its potential associations with immigration-related factors such as migration reasons, years in U.S., acculturation, and ethnic enclave residence. Using data from the Population-based Study of Chinese Elderly in Chicago (collected 2013-2015, N=3,123), this study investigates whether and how immigration-related factors shape mental health service utilization. Four categories of help-seeking behaviors for depressive symptoms were examined, including not seeking help (23.5%), seeking help from informal source(s) only (40%), seeking help from both informal and formal sources (28.7%), and seeking help from formal source(s) only (8.8%). Results of logistic regressions showed that U.S. Chinese older adults who migrated for family reasons were less likely to seek help from informal sources only than those who migrated for other reasons [Odds Ratio (OR)=0.64, 95% Confidence Interval (CI)=0.42-0.99). Less acculturated older immigrants (OR = 0.88, 95% CI = 0.79-0.97) and those who lived in Chinatown (OR = 2.34, 95% CI = 1.21-4.52) were more likely to seek help from formal sources only (relative to not seeking any help). Our findings showed that majority of the older Chinese Americans with depressive symptoms either did not seek help or sought help from informal sources only. Their help-seeking behaviors were shaped by their migration and acculturation experiences. Leveraging informal support networks and ethnicity-specific resources in Chinatown represent a culturally appropriate approach to facilitate mental health help-seeking among U.S. Chinese older adults.

ROLE OF DISEASE-SPECIFIC INCIDENCE AND SURVIVAL IN DISPARITIES IN LIFE EXPECTANCY IN THE UNITED STATES

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There are persisting geographic and racial disparities in life expectancy (LE) across the United States (US). We used 5% Medicare Claims data (2000-2017) to investigate how disease incidence and survival contribute to such disparities. Disease-specific hazard ratios (HRs) were calculated for Medicare beneficiaries living in the US states with the lowest LE (the states with the highest LE were used as a reference group), in gender- and race-/ethnicity-specific populations. Analysis of incidence showed that the greatest contribution to between-the-state disparities in LE was due to higher incidence (HRs≥1.30) of atherosclerosis, heart failure, influenza/pneumonia, Alzheimer's disease, and lung cancer among older adults living in the states with the lowest LE. The list of diseases that contributed most to LE through the differences in their survival substantially differed from the above listed diseases: namely, diabetes, chronic ischemic heart disease, and cerebrovascular disease had HRs≥1.28 for their respective survival rates, with the highest HRs for lung cancer (HR=1.37, in females) and prostate cancer (HR=1.30). Respective race-/ethnicity-specific patterns of incidence and survival HRs were investigated and diseases contributed most to racial disparities in LE were identified. Study showed that when planning the strategies targeting between-the-state differences in LE in the US, it is important to address both 1) primary and secondary prevention for diseases demonstrating substantial differences in contributions of incidence, and 2) treatment choice, adherence to treatment, and comorbidities for diseases contributing to LE disparities predominantly through the differences in survival. Such strategies can be disease-, race-/ethnicity-, and geographic area-specific.

SLOWDOWN IN LIFE EXPECTANCY IMPROVEMENTS FOR EUROPEAN COUNTRIES FROM 2000 TO 2019

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Life expectancy improvements have slowed across Europe since around 2010 for unknown reasons. We aimed to assess