been introduced in many countries. These policies include raising state pension age and linking the amount of state pensions more closely to years spent in paid employment. Such policies tend to be undifferentiated by gender or health status – in most countries, state pension age has been raised to the same age for men and women. Yet, research evidence indicates that women in all countries are disadvantaged in relation to employment at older ages and pensions. There are also health inequalities for older workers, depending on their occupation and whether they are in precarious or secure employment. Extended working life is of pressing societal concern. This symposium brings together the work of a group of leading international scholars who have been researching and reflecting on its implications in a forthcoming book on the topic across 34 countries. The symposium begins with an overview and analysis of the empirical landscape of older employment and pension policy by Martina Rasticova and Jim Ogg; Paper 2 offers a discussion of the theoretical perspectives and policy debates across 34 countries by Clary Krekula; there will be an analysis of extended working life policy in Ireland by Aine Ni Leime and a final presentation synthesising policy recommendations and mapping future research directions in extended working life by Debra Street.

GENDER, HEALTH, AND EXTENDED WORKING LIFE IN IRELAND

Aine Ni Leime[1], *1. National University of Ireland, Galway Ireland, Galway, Ireland, Ireland*

This presentation is based on a forthcoming book chapter which analyses policies, statistical evidence and qualitative data to investigate the gender and health implications of Extended Working Life policy in Ireland. The qualitative data is from a study conducted in 2018 that investigated attitudes to extended working life and experiences of late life work among sixty older workers, 30 men and 30 women in three different occupations, health care workers/cleaners, teachers and academic faculty.The data were analysed using a lifecourse approach. Workers in physically-demanding occupations, those in precarious employment and women were found to be more likely to be disadvantaged in relation to options for extending their working lives. It is recommended that policies be modified to address the disadvantages faced by these groups of workers.

PROBLEMS AND PROSPECTS FOR CURRENT POLICIES TO EXTEND WORKING LIVES

Debra A. Street,[1] and Debra A. Street[1], *1. State University of New York at Buffalo, Buffalo, New York, United States*

Current policy debates fluctuate between "extending working life" and "delaying retirement"—assuming policies that reflect different conceptual approaches are identical. This presentation uses a different analytic strategy, conceptualizing later life work policies as representing distinctive approaches to consideration of work conditions/income security for older workers. Using data from over 30 countries, I discuss main trends in extended working life policies (mainly in the EU) and the gender and health implications for current and future workers. We find that policies committed to "extending working life"—supporting adequate/meaningful employment for later life work—are enacted rarely, but with potentially positive effects for the health and wellbeing of older workers of either gender. However, "delaying retirement" policies, which dominate the political landscapes of most of the country-specific policies we consider, reproduce or exacerbate gender inequalities and health risks for vulnerable older workers.

PUTTING THE CONTEXT BACK INTO THE DEBATE ON EXTENDED WORKING LIFE

Clary Krekula[1], *1. Karlstad University, Karlstad, Sweden*

Policy on extended working life has tended to focus on individuals. The debate has to a great extent described older people as the problem and their current retirement trends as problematic as well as selfish, uninformed, out-dated and a threat to welfare provision and benefits. This depicts the political initiatives as a phenomenon disconnected from social, political and economic trends. This presentation reintroduces the context, by locating the role of policies to extend working lives as forming part of a neoliberal policy agenda. Starting from the understanding that policies are proactive measures which focus on some aspects and play down others, this paper analyses international policies from the EU and OECD and also government policies from 34 European countries. The results draw attention to the narrow and contradictory ways in which the issue is often framed, and how this relegates related new inequalities to the background.

EXTENDED WORKING LIFE POLICIES: INTERNATIONAL GENDER AND HEALTH PERSPECTIVES, EMPIRICAL AND POLICY LANDSCAPE

Martina Rasticova,[1] and Jim Ogg[2], *1. Mendel University, Brno. Czech Republic, Brno, Czech Republic, 2. French National Pension Fund (Caisse nationale d'assurance vieilliesse), Paris, Ile-de-France, France*

As populations age, extending the working life appears to be widely accepted and promoted by governments (OECD 2006; 2017). Without exception, all countries with modern economies have responded in one way or another to the financial challenges arising from increased life expectancy and ageing populations. Policies to extend working life are ubiquitous, each based on the premise that unsustainable pension systems must be reformed, and public spending reduced. Although there are diverse perspectives on extended working life, gender and health consistently prevail as key dimensions. To date, policies extending working life have not taken sufficiently into account these two dimensions. A clear example in the case of gender concerns the shift towards equality in retirement ages between men and women. In this presentation, we set the stage by presenting the empirical and policy landscapes across 34 countries that characterise the trend of extended working life from gender and health perspectives.

SESSION 4130 (PAPER)

HEALTH CARE AND HOSPITALIZATION

AN INFLAMMATORY SIGNATURE OF POSTOPERATIVE DELIRIUM

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Delirium is a common, morbid, and costly geriatric syndrome, yet its pathophysiology remains poorly understood. In a nested matched case-control study within the Successful Aging after Elective Surgery (SAGES) study, a cohort of adults age ≥70 without dementia undergoing major non-cardiac surgery, we previously identified inflammatory proteins to be associated with delirium. Using the entire SAGES cohort, the current study examines the independent associations of these inflammatory proteins with postoperative delirium. Plasma was collected preoperatively (PREOP) and on postoperative day 2 (POD2). Neuroinflammatory marker chitinase-3-like protein [CHI3l1 or YKL-40]; PREOP and POD2) and systemic inflammatory markers interleukin [IL]-6 (POD2 only) and C-reactive protein (CRP; PREOP and POD2) were measured using enzyme-linked immunosorbent assays. Generalized linear models were used to determine the independent (multivariable) associations between the inflammatory markers, measured in sample-based quartiles (Q). All models adjusted for age, sex, baseline cognition, surgery type, Charlson comorbidity index, and medical complications. Among the 555 patients (mean age 77 years, standard deviation, SD 5.2), 58% were female and 86% underwent orthopedic surgeries. Postoperative delirium occurred in 24%. High YKL-40 PREOP and IL-6 at POD2 (Q4 vs. Q1) were significantly associated with an increased risk of delirium: relative risk (RR) [95% confidence interval (CI)] 2.2[1.1-4.4] and 2.7[1.3-5.7], respectively. CRP (PREOP and POD2) was not significantly associated with delirium (p=0.37 and p=0.73, respectively). This work underscores the importance of inflammation (YKL-40 and IL-6) in the pathophysiology of postoperative delirium.

FACTORS ASSOCIATED WITH MORTALITY AMONG LONG-TERM CARE RESIDENTS TRANSITIONING TO AND FROM EMERGENCY DEPARTMENTS

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Studies examining risk of death during acute care transitions have highlighted potential predictors of death during transition. However, they have not closely examined the relationships and directional effects of organizational context, care processes, resident demographics and health conditions on death during transition. By employing structural equation modeling, we aimed to 1) identify predictive factors for residents who died during transitions from long term care (LTC) to emergency departments (EDs) and back; 2) examine relationships between identified organizational, process and resident factors with resident death during these transitions; and 3) identify areas for further investigation and improvement in practice. We tracked every resident transfer from 38 participating LTC facilities to two included EDs in two Western Canadian provinces from July 2011 to July 2012. Overall, 524 residents were involved in 637 transfers of whom 63 residents (12%) died during the transition. Sustained dyspnea (in both LTC and the ED), sustained change in level of consciousness (LOC) and severity measured by triage score were direct and significant predictors of resident death during transition. The model fit the data, ($x2 = 83.77$, $df = 64$, $p = 0.049$) and explained 15% variance in resident death. Dyspnea and change in LOC in both LTC and ED needs to be recognized regardless of primary reason for transfer. More research is needed to determine the specific influences of LTC ownership models, family involvement in decision-making, LTC staff decision-making on resident death during transition, and interventions to prevent pre-death transfers.

LONG-TERM CARE FACILITY VARIATION IN THE INCIDENCE OF PNEUMONIA AND INFLUENZA HOSPITALIZATIONS

Elliott Bosco,[1] Andrew Zullo,[1] Kevin McConeghy,[2]
Patience Moyo,[1] Robertus van Aalst,[3] Ayman Chit,[3]
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Pneumonia and influenza (P&I) increase morbidity and mortality among older adults, especially those residing in long-term care facilities (LTCFs). Facility-level characteristics may affect P&I risk beyond resident-level determinants. However, the relationship between facility characteristics and P&I is poorly understood. We therefore identified potentially modifiable facility-level characteristics that might influence the incidence of P&I across LTCFs. We conducted a retrospective cohort study using 100% of 2013-2015 Medicare claims linked to Minimum Data Set 3.0 and LTCF-level data. Short-stay (<100 days) and long-stay (≥100 days) LTCF residents aged ≥65 were followed for the first occurrence of hospitalization, LTCF discharge, Medicare disenrollment, or death. We calculated LTCF risk-standardized incidence rates (RSIRs) per 100 person-years for P&I hospitalizations by adjusting for over 30 resident-level demographic and clinical covariates using hierarchical logistic regression. The final study cohorts included 1,767,241 short-stay (13,683 LTCFs) and 922,863 long-stay residents (14,495 LTCFs). LTCFs with lower RSIRs had more Physician Extenders (Nurse Practitioners or Physician's Assistants) among short-stay (44.9% vs. 41.6%, p<0.001) and long-stay residents (47.4% vs. 37.9%, p<0.001), higher Registered Nurse hours/resident/day among short-stay and long-stay residents (Mean (SD): 0.5 (0.7) vs. 0.4 (0.4), p<0.001), and fewer residents prescribed antipsychotics among short-stay (21.4% (11.6) vs. 23.6% (13.2), p<0.001) and long-stay residents (22.2% (14.3) vs. 25.5% (15.0), p<0.001). LTCF characteristics may play an important role in preventing P&I hospitalizations. Hiring more Registered Nurses and Physician Extenders, increasing staffing hours, and reducing antipsychotic use