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Backgrounds: In general, women report more physical and mental complaints than men. This study aims to evaluate (1) whether there are sex inequalities in work characteristics (grades of employment, job control, demand, and work hours) and health as measured by the Short Form 36 (SF-36) and (2) whether the work characteristics contribute to some of the sex inequalities in health among employees from Britain, Finland and Japan.

Methods: The participants were 7340 (5122 men and 2218 women) British employees, 2297 (1638 men and 659 women) Japanese employees, and 8164 (1649 men and 6515 women) Finnish employees. All the participants were civil servants aged 40–60 years.

Results: In the age-adjusted model, significantly more women than men had low control in Britain and Japan. More women than men had high demands in all cohorts. While more women than men had long work hours in Japan, the opposite was true for the British and Finnish cohorts. Compared with men, the age-adjusted odds ratio (OR) for poor physical functioning was 2.08 (95% confidence interval: 1.86–2.32) for British women, 1.72(1.42–2.09) for Japanese women, 1.51(1.32–1.73) for Finnish women. The OR for poor mental functioning was 1.45 (1.30–1.63) for British women, 1.91(1.56–2.34) for Japanese women, 1.07(0.94–1.22) for Finnish women. When the work characteristics were adjusted for, the sex inequalities in physical and mental functioning were mildly to moderately attenuated in all cohorts.

Conclusions: Women tended to have disadvantaged work characteristics. These sex differences in the work characteristics may explain some of the sex inequalities in health.

43. Gender Differences in the Treatment of Myocardial Infarction

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Background: If women are at greater risk for worse outcomes associated with acute coronary syndrome (ACS) than are men, as many studies suggest, one explanation may be that they tend to be treated less aggressively than men even when more aggressive treatment is warranted. The purpose of this analysis was to assess this issue.

Methods: We used the CRUSADE (Can Rapid Risk Stratification of Unstable Angina Patients Suppress Adverse Outcomes with Early Implementation) registry, an observational data collection and quality improvement initiative that began in November 2001.

We stratified 18,480 men and 11,661 women into 32 cells, based on four age groups (<65, 65–74, 75–84, 85+), four cardiac catheterization findings (insignificant, 1-vessel disease, 2-vessel disease, 3-vessel disease), and biochemical evidence of myocardial infarction (troponin *and* CK-MB above upper limits of normal – yes vs. no) in subjects with acute onset of typical cardiac chest pain and no ST segment elevation on ECG. In each cell we compared the rate of surgical treatment (CABG or PCI) for men versus women.

Results: Men demonstrated significantly higher rates ($p < 0.05$) of surgical treatment in 10 of the 32 cells, compared to no cells in women. These cells included only the 18 with the three youngest age categories and insignificant, 1-vessel disease, or 2-vessel disease cardiac catheterization findings.

Conclusion: These findings strongly suggest that men are more likely than women to be surgically treated, when presenting with evidence of non-ST segment MI, and when controlled for age, cardiac catheterization findings and biochemical evidence of MI.

44. Biopsychosocial Factors and Perinatal Healthcare Decisions Among Primiparous and Multiparous Pregnant Women

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Background: Primiparous women tend to be less satisfied with their childbirth experiences than women who have already delivered a baby. Obstetric complications, perceived control and support are also thought to influence childbirth satisfaction. However, little is known about how prenatal factors affect healthcare decisions that often shape the birth experience. This study examined whether demographic characteristics, risk status, desire for control, and health locus of control are related to healthcare choices (i.e. medical provider, labor support, childbirth preparation, birth location) among primi- and multiparous women.

Method: Pregnant women ($N = 193$; mean age 29.2; 83% Caucasian; 30% high-risk; 39% primiparous) completed a Prenatal Health Survey, the Desire for Control in Childbirth Behavior Scale (DCCh-B) and the Multidimensional Health Locus of Control Scales for Labor/Delivery (MHLC-LD).

Results: High desire for control significantly predicted choosing non-traditional providers i.e. midwives and doulas (OR: 5.5; 95% CI = 2.1–14.5; $p < .01$) and birth centers vs. hospitals (OR: 6.1; 95% CI = 1.2–30.1; $p < .05$). Demographic variables, parity, risk status, and health locus of control failed to predict these choices. No significant differences between primiparous and multiparous women emerged for any healthcare choice ($\chi^2 = .3$–1.0, $p > .05$). However, parity was positively correlated with desire for control ($r = .14$, $p < .05$) and inversely correlated with "Others" locus of control ($r = -.22$, $p < .05$).

Conclusions: Prenatal desire for control could affect perinatal care decisions of both primiparous and multiparous women. Primiparous women may desire less personal control during childbirth and attribute more control of outcomes to other people than multiparous women.