Time, Patience, and Black People: A Study of Temporal Access to Medical Care*

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Because it stands as a barrier to convenient access, delay is an important feature of medical services. To be properly understood, however, this dimension must be decomposed into its objective and subjective properties, the former indexed by waiting time; the latter, by impatience. Data from a national sample show that black people not only wait longer for medical service than whites; they also display more displeasure per unit delay. This finding is inconsistent with the popular assumption that blacks are more indifferent to time costs than whites. Black impatience and its adverse consequences on utilization of medical service are magnified among the more radical and socially disadvantaged. These results stem not from values and attitudes specifically related to time but from a diffuse negativity evoked by the adverse social conditions under which black people live. This broader context places limits on the extent to which increased patient satisfaction can be achieved by objective changes in the organization and distribution of medical service alone.

During recent years, social scientists have become increasingly sensitive to the costs of delay in the acquisition of services. Two approaches have been employed in the description and analysis of this problem. The first approach is that of queuing theory, a well established component of operations research whose application to problems in service delivery has become common. The subject matter of this discipline includes priority rules, queue structures, and simple supply-demand ratios. However, sociologists have begun to link these immediate determinants of waiting time, which operate at the organizational or "service system" level, to a more general institutional context. A number of facts relevant to the question of racially patterned inequalities in temporal access to goods and services have emerged from this second set of inquiries.

The purpose of this investigation is not to explain further the reasons why black consumers incur higher time costs in the acquisition of goods and services than white consumers (Schwartz, 1975:110-131; 1977). Instead, it takes up the argument that no relationship would exist between race and the time cost incurred in acquiring service if the length of delay were weighted by the foregone value associated with it. This argument can only mean that time is less precious among blacks. Let us consider the rationale on which this assumption is based.

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One may suppose that the distress of waiting is a manifestation of the opportunity costs of time, that is to say, the value foregone in waiting that could have been put to more productive use elsewhere. Economists, of course, assert that the value of foregone time is directly proportional to earned income (see, for example, Becker, 1965; Nicholas, et al., 1971). It is the poor, therefore, who are said to be least likely to "balk" or refuse to enter a queue; they are also assumed least likely to "renege" or abandon a queue after having joined it. While the poor may have something *else* to do beside sitting and waiting, they might not have anything *better* to do. This kind of argument, which sounds reasonable enough, is not only advanced in theoretical discussion; it is also put to use by econometricians in their estimates of the value of time.

If earned income is to be used as a measure of its worth, then black time must surely be considered less valuable than white time. However, there is another reason to attribute inferior value to the time of black people. This is based on a cultural rather than an economic premise. Because of a reputedly slow-paced and easy-going life style, blacks are assumed to be insensitive to the demands and strictures of time. In contrast, whites consider themselves to be more respectful of schedules and appointments, and more willing to gear their fast-paced lives to the clock. This difference is expressed in the image of the harried but punctual white bureaucrat, on the one hand, and the black "Step 'n Fetch It" caricature, on the other hand. It is also expressed in the notion that "White People's Time" is qualitatively different from "Colored People's Time."[1] It would be reasonable to assume, then, that while blacks wait longer, a longer wait is not as costly to them as a shorter one is to whites.

These ideas can be readily tested if we are willing to make one assumption, namely, that those whose time is most scarce and valuable are those who are most likely to feel opporessed when it is wasted.

DATA COLLECTION AND MEASUREMENT

The data on which this investigation is based were drawn from a comprehensive survey on health care use, expenditures, attitudes, and practices. This information was collected in 1970 by the National Opinion Research Corporation (NORC) according to the general design of the Center for Health Administration Studies of the University of Chicago.

The universe sampled is the total non-institutionalized population of the United States. However, since the broader study was designed to answer a number of specific health policy questions, those segments of the population which were the targets of these questions were over-represented. These include people with low incomes, those living in central cities, the rural population, and persons 66 years of age and over. A weighting scheme was devised to compensate for this stratification procedure. The correction was based on a juxtapositioning of the U. S. Census and NORC sample distributions of 16 population classes defined by family size, family income, race, and whether or not the family dwelling unit is located in a metropolitan area.

Included in the NORC survey are 11,619 (unweighted) residents of 3,828 households. But since the members of a family tend to use the same clinic or doctor

for routine care, we shall confine our inquiry to the heads of the sample households. This selection obviates redundancy in the representation of sources of care; it also avoids exaggeration of the empirical patterns in which we are interested.

Because information on waiting time was obtained only in reference to regular source of care, those heads of household who could claim no such source have been eliminated from the sample. Also excluded are those not designated as black or white and those whose source of care is not an M.D. or osteopath. This procedure reduces the number of usable cases to 3,210. However, the several respondents who failed to provide information on their usual waiting time further reduced the sample to 3,180. This figure converts to 15,766 weighted cases.

In this investigation we use a dichotomous income measure which reflects level of earnings in relation to family size. This measure was formulated by the U. S. Department of Labor.[2]

The measure of waiting time is a response to the following question: "How long do you usually have to wait to see the doctor, once you get to his office?" The distribution of responses was dichotomized at thirty minutes. Those usually delayed for less and more than half an hour were defined as having short and long waiting times respectively.

Dissatisfaction with waiting time was evaluated by drawing on information from the Health Opinions Questionnaire segment of the household survey. This instrument yields information on client impatience by calling on each respondent to rate along a four-point scale their "satisfaction with waiting time in doctors' offices and clinics." By combining the responses "Very dissatisfied" and "Dissatisfied," we obtained an overall measure of impatience. This is obviously a very crude measure. On the other hand, its strong association with waiting time means that the item has at least a satisfcatory degree of construct validity. Information on this variable was available for about 80 per cent of all black or white heads of household with a regular source of care (for whom usual waiting times could be ascertained). The resulting 2,488 cases (transformed by the weighting procedure to 12,567) represents 78 per cent of the eligible sample for which information on waiting time is available and 65 per cent of all households surveyed.

RESULTS

If, by reason of inferior income and a value system which denies its importance, black people hold their own time in low regard, then two results should obtain. Regardless of the length of their delay, blacks should exhibit less dissatisfaction with waiting time than whites. Part, but not all, of this association should be accounted for by income level; the unexplained portion should be attributable to the "Colored People's Time" syndrome.

The outcomes presented in Table 1 are inconsistent with these assumptions. The frequencies in this table show that, within the high-income group, 36 percent of the whites and 50 percent of the blacks are delayed for more than 30 minutes at their regular source of care. In the low-income group the comparable percentages are 51 and 69. But this pattern is not negated by countervailing variation in dissatisfaction. The lower right hand margin of Table 1 shows 34 percent of the white respondents to

TABLE 1

PERCENTAGE DISSATISFIED WITH WAITING TIME BY WAITING TIME, INCOME LEVEL, AND RACE

Race	Waiting Time					
	Short		Long		Total	
			Low Income			
White	21	(1175)	49	(1238)	35	(2413)
Black	33	(206)	59	(468)	51	(674)
Total	23	(1381)	52	(1706)	38	(3087)
			High Income			
White	25	(5689)	51	(3253)	34	(8942)
Black	32	(271)	51	(267)	41	(538)
Total	25	(5960)	51	(3520)	34	(9480)
			Total			
White	24	(6864)	50	(4491)	34	(11,355)
Black	33	(477)	56	(735)	46	(1,212)
Total	25	(7341)	51	(5226)	35	(12,567)

be dissatisfied with the amount of time they spend waiting in doctors' offices and clinics; the percentage impatient among blacks, however, is 46 percent. This relationship is only partly explained by the fact that blacks wait longer for their service. Among those whose usual waiting time is less than 30 minutes, 24 percent of the whites and 33 percent of the blacks express dissatisfaction with waiting time. The same percentages for those whose usual waiting time is more than 30 minutes are 50 and 56. Both differences are statistically significant beyond the .05 level.[3] Thus, it is the blacks, not the whites, who exhibit the most impatience per unit waiting time.

Income differences are more difficult to detect. Looking to the right-hand column totals, we find those of low rather than high income to be most displeased with their delay. Thirty-eight percent of the former and 34 percent of the latter express dissatisfaction in this respect. However, when waiting time is held constant this effect ceases to be significant.

We must note, however, that the relationship between waiting time satisfaction and race is especially pronounced in the low-income group. As Table 1 shows, blacks here exceed whites in percentage impatient by 12 points in the short waiting time interval and by 10 points in the long interval. The comparable differences in the high-income group are seven and zero (neither of which is statistically significant). On the other hand, if the effect of waiting time itself is somehow conditioned by race, it is very hard to detect how. Long delays increase the percentage dissatisfied by 26

points among whites and 24 points among blacks. This invariance seems to prevail at both income levels.

What we find, then, is that while delay is determined by both race and income, dissatisfaction with waiting time is affected exclusively by race. The problem we now face is to explain this tendency. In this regard, a number of accounts come to mind, and we explored them all. Specifically, we considered black-white differences in health, readiness to consult physicians, age, sex, education, and source of care. The direction of race effects was maintained when these factors were held constant; however, their magnitude appeared to be greater in some sectors of the population than in others. Thus, when partialled on waiting time, the mean percentage race difference (our measure of the extent to which blacks exceed whites in impatience)[4] varies as follows for age, sex, education, and source of care:

Age	Below 40:	10.5
	Above 40:	4.0
Sex	Male:	14.0
	Female:	2.0
Education	Less than 12 years:	14.5
	12 years or more:	3.0
Source of Care	Clinic:[5]	14.5
	Private Doctor:	4.3

These figures show that while black clients consistently display more impatience than whites, the strength of this tendency is not invariant. Regardless of waiting time, race differences are pronounced (and statistically significant) only among the poor, the young, males, the least educated, and clinic patients.[6] In other words, the races differentiate themselves most conspicuously in the more socially radical (young, male) and least advantaged sectors or society.

DISCUSSION

The results leave open the question of why blacks should be the ones to experience the most distress in regard to delay. However, there is actually a prior issue directly related to this question, namely, does black antipathy thoward being delayed have to do with a specific orientation toward time, or to a more general attitude under which questions relating to time may be subsumed? There are two reasons to assume the latter account to be most credible. First, a review of the tables we just summarized showed that the effect of *waiting time* on client impatience is not consistently greater among blacks (regardless of their status or experiences) than it is among whites. On the other hand, differential values and attitudes regarding time do not absolutely require such a difference. Therefore, to prove that white-black variation in a general rather than a specific disposition is what generates differences

in impatience, we must not only demonstrate an absence of unusually pronounced waiting time effects among blacks; we must also show blacks to be more discontent than whites in matters relating to things other than time.

In a separate analysis, we broke down impatience rates by race and income on 11 dimensions of medical care delivery, namely, overall quality of care, availability of night care, ease of getting to doctor, out-of-pocket costs, information about illness and home treating, doctor and nuse courtesy, follow-up care, doctor's concern with overall health, and whether all needs could be met at one location. On 9 of these 11 dimensions, blacks display more dissatisfaction than whites. The direction of this relation holds in *both* income groups on 8 dimensions. In only one respect, ("All needs met at one location") do whites, regardless of income, express most disapproval. There can be no doubt that part of this pattern is due to differential experience. However, we do know that attitudes toward waiting time are not fully explained by delay itself, and we found that attitudes toward cost of care are not to be accounted for by actual income. If these two findings are representative of the other dimensions of care, then we may assume on the part of blacks a general, if not highly developed, readiness toward negative evaluation—a vague bitchiness, so to speak, which also conditions their evaluation of waiting time. Such a conclusion is altogether consistent with another nationwide survey which, in comparing blacks' and whites' evaluation of a variety of services, finds the blacks consistently most ready to be displeased (Katz, et al., 1975:77-101). But what can be the basis of this?

Although we are not in a position to say anything certain, there is at least some reason to assume that black dissatifaction in medical establishments is in large measure a reflection of feelings evoked by social conditions in general. After all, the data we are considering were gathered in 1970, which was the end of almost a decade of social unrest, confusion and anger. If this decade contained more promise than it could fulfill, and if, in particular, the expectations of the black minority expanded faster than did the objective means to realize them, then 1970 could truly be called—if one may pardon the expression—a "year of impatience." This context must have been fertile ground for the development of an overarching set of anti-white attitudes and an attending negativism toward many aspects of service provided by or associated with a white establishment.

Unfortunately, there are no data in the present survey that would enable us to test this explanation. In the absence of internal or direct verification, however, we might turn to an indirect procedure. Specifically, if the difference between blacks and whites in our data is related to the historical malaise to which we have just alluded, then variations within the black population in respect to impatience with medical queues should trace the same pattern as that into which black thinking in general falls. It so happens that this is the case. Not only attitudes toward waiting time in doctors offices but also toward separatism, alienation, violence, genocide fears and race consciousness are most radically negative in the younger as opposed to the older segments of the black population, among males more than females, among those of low rather than high education and income. These facts, which have been recently documented by Turner and Wilson (1975) in their comprehensive survey of urban blacks, agree point by point with the findings we have presented and are therefore consistent with the argument we have advanced to account for them. In turn, the

present data provide further support for the view that, owing to the dramatic visibility of the black protest movements of the 1960s, the discontent and impatient are no longer confined to the more privileged sectors of the black community (Marx, 1960). The pivot of relative deprivation has shifted decisively downward. This change has been unambiguously registered in the sphere of medical care.

IMPATIENCE AND UTILIZATION OF MEDICAL SERVICES

At question is not only the validity of this statement, which we have tried to document, but also whether, from the standpoint of medical care, there is anything at stake in it. If blacks are least satisfied with the service they receive, can we say that their displeasure has any consequence beyond the affirmation of certain views on militancy in race relations? Specifically, does the Negro's impatience reduce the extent to which he utilizes medical services? And, if so, does it reduce utilization more than is the case among whites? A separate analysis produced an affirmative answer to both questions.

The absolute reduction in the annual number of visits to doctors' offices brought about by a 1-step increase in waiting time dissatisfaction among whites and blacks was determined by a regression procedure. Four indicators of health as well as income, travel time, and appointment and office waiting times were held constant. The results show that a unit increment in dissatisfaction reduces utilization by .54 or about one half a visit annually among whites and by .98 or about one visit annually among blacks.[7] We also found that a unit increase in dissatisfaction reduces the annual number of doctor visits substantially more among low income blacks (1.28) than among higher income blacks (.52).

To account for these results, at least two explanations may be advanced. The one which is perhaps most widely held assumes that blacks and whites differ in their reaction to physical stress. Because black people are more "stoic," more indifferent to their own physical well-being, the argument goes, their demand for medical care is "elastic" and readily inhibited by negative feelings evoked in the process of obtaining it. In contrast, whites are less heroic in the face of symptoms and discomfort; the demand of the white person is therefore "inelastic" or "indifferent" to his own impatience. However, when we held constant the differences between blacks and whites in the number of symptoms experienced during the year, which is one more or less objective measure of overall health, we found that blacks register the lowest score on a self-reported health scale. (On this scale, higher scores indicate better health.) The partial correlations, where blacks are coded 2; whites, 1, are -.09 and -.09 for persons under and over 40 years of age. This health scale taps a person's subjective rating of his physical condition, the measure of his concern with it, and the extent to which he experiences bodily discomfort. That blacks score significantly lower than whites on this scale is not consistent with a view which attributes to them a cavalier attitude toward their own well-being.

A more credible explanation of these findings is simply that delay holds a different meaning for blacks than it does for whites. It is not only that blacks are more impatient than whites; their impatience must also evoke a qualitatively distinct set of ideas and sentiments—a difference which finds expression in

contrasting correlations with utilization. This state of mind is probably related to the syndrome we have already described: diffuse anger, resentful negativism, and a readiness to be displeased.[8] In an era of black liberation, of heightened awareness of entitlements to economic and social rewards, it can be no surprise that waiting (which is a direct expression of dependence and subjugation [Schwartz, 1975:13-46; 167-183]) is oppressive enough to bring about a renunciation of otherwise valuable services.

Although they related in substanced to the dimension of time, the above statements are reminiscent of those unique psychological manifestations of the money economy (the "miser" and the "spendthrift") so cogently particularized by Simmel (1971:179-186). At first thought, this analogy might seem farfetched, but the slightest consideration will show that it is not. What is important about Simmel's types is that they embody in simple point and counterpoint the manifold emotional aspects of money, which is the medium (not the source) of their representation. It is simply that certain inner tendencies find preferential affinity for money as a vehicle of outward expression and would assume an altogether different symptomatic form in its absence. Likewise, there are certain psychological states bound by their intrinsic nature to delay and waiting. Just as the actions of the miser and spendthrift are predicated upon money, rather than specific amounts of money, so the existence of the impatient presumes a preceding interval of delay, but not any particular amount. And, parallel to the motivation of the miser and the spendthrift, it is in a willingness to forego or incur the costs of desirable benefits that distinguishes the patient and the impatient.

What we have done in this inquiry is not to delineate the impatient as a social type but to show how impatience as a psychological form emerges from the perspectives of a disadvantaged minority in an era of rising expectations. And it is here that a remarkable irony enters in. Just at that point where earlier deprivations begin to give way, where previously scarce services are made increasingly available, the psychological states occasioned by these deprivations create barriers from within, obstacles which inhibit the utilization of benefits as effectively as did the earlier external impediments. The wrath and resentment issuing from an outmoded and pernicious morality turn in upon the physical being of their source with the effect and certainty of a slow poison. In earlier times the disadvantaged were ruined by the venom of others; today, through an ironical connection, they deprive and ruin themselves.

SUMMARY

Because it stands as a barrier to convenient access, delay must be considered as an important feature of services in general and health care services in particular. To be properly understood, however, this dimension should be decomposed into its objective and subjective properties, the former indexed by waiting time, the latter, by dissatisfaction with waiting time. The intention of many economists who have considered the problem is to reduce this duality to a single plane. By adopting the assumption of an unrestricted convertibility of time and money, they have subsumed all vicissitudes in delay and its costs under a simple monetary model. The present

paper demonstrates the incompleteness of this line of argument as it applies to the meaning of waiting.

There is, of course, a cumulative aspect to the parallel between the objective and subjective elements in delay. On the one hand, while blacks wait longer than whites, poor blacks wait much longer than poor whites. On the other hand, while blacks display more displeasure than whites per unit delay, this effect, too, as well as its own adverse consequences on utilization, is magnified among the disadvantaged. It is as if nature designed a conspiracy to ensure that those who lose most in one respect will also lose most in the other. Thus, if we weighted the magnitudes of white and black waiting time by their "unit costs," measured in terms of expressed impatience, the black-white inequality incurred in consumption-time costs would be considerably larger.

In conclusion, there *is* a valid distinction to be made between "White People's Time" and "Colored People's Time." However, our preconceptions have stood in the way of a genuine appreciation of this difference. It is not the white, but, rather, the black who is most likely to complain about the time it takes to acquire service. The notion that it is the other way around, that the time of the black man has no value, is a myth which derives from an ideology that socially degrades him. Furthermore, the "Colored People's Time" syndrome, as presently revised, has been found to consist not so much in a specific orientation toward time itself as in a generalized discontentment brought about by the black's recently heightened sensitivity to his social condition. Nevertheless, the impatience in which this discontentment finds expression is activated through the delay imposed by those who provide medical services—whose use is thereby inhibited.

FOOTNOTES

1. John Horton (1970:44) advances the view that "Colored People's Time" is a variant of lower class "street time." However, he also points out that "middle class Negroes who must deal with the organization and coordination of activities in church and elsewhere will jokingly and critically refer to a lack of standard time sense when they say that Mr. Jones arrived 'CPT' (colored people's time)." It is Herskovits's (1941:153) contention that Colored People's Time may be traced to the lax time sense of traditional African society.

2. The 1970 cut-off points for "low income" by family sizes 1 to 7 + are $2,600, $3,700, $4,500, $5,700, $6,600, $7,500 and $9,100.

3. P values were obtained by dividing the differences observed in the weighted sample by standard errors calculated on the basis of unweighted observations. Because the respondents in this survey do not constitute a simple random sample of the United States population, the test for significance of the difference between proportions uses an underestimate of the standard error of this difference. However, because the resulting Z values well exceed the .05 level for almost all significant differences, and because they fall well below that level for almost all insignificant differences, we are entitled to employ the .05 criterion with confidence. Another consideration sustains us in this judgement. Approximately 10 percent of the total sample reports no regular source of care. These respondents, for whom no waiting time information is available, have been excluded from the present sample. The great majority of these respondents are classified in the low income group. Because race differences in impatience are most pronounced in this same group, we may assume that if information on excluded respondents were available we would have even more confidence in the results.

4. The mean difference in percentage impatient in the short and long waiting time intervals is *unweighted.* It therefore constitutes a measure of partial association.

5. Clinics are defined as facilities which do not assign patients to particular doctors. These "multiple-server" facilities are distinguished from clinics which are occupied by private doctors who see their own patients.

6. Race differences in impatience satisfied the .05 significance criterion in both the short and long waiting time categories among those under 40, males, non-high school graduates and clinic patients. Although blacks tended to exceed whites in impatience among other groups (those above 40, females, high school graduates and private doctors' patients), none of the differences remained significant when waiting time was controlled.

7. This and all subsequent association coefficients referred to in the text are statistically significant.

8. Our data do not put us in a position to explore the psycho-dynamics which produce this syndrome. One may at least speculate, however, that the negative attitude of blacks toward medical and other services may represent a "displacement" of a more generalized and unconscious hostility. This idea is consistent with views set forth in the work of Kardiner and Ovesey (1962) and Crain and Weisman (1972).

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