

The Myth of Meritocracy and African American Health

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Recent theoretical and empirical studies of the social determinants of health inequities have shown that economic deprivation, multiple levels of racism, and neighborhood context limit African American health chances and that African Americans' poor health status is predicated on unequal opportunity to achieve the American Dream.

President Obama's election has been touted as a demonstration of American meritocracy—the belief that all may obtain the American Dream—and has instilled hope in African Americans. However, we argue that in the context of racism and other barriers to success, meritocratic ideology may act as a negative health determinant for African Americans. (*Am J Public Health*. 2010;100:1831–1834. doi:10.2105/AJPH.2009.186445)

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Barack Obama spoke at the NAACP at its centennial celebration, articulating a common goal for the association and his administration: “We want everyone to participate in the American Dream.” He argued that although poor and African American children face social challenges, these challenges need not stop their success: “No one has written your destiny for you. Your destiny is in your hands. . . . That’s what we have to teach all our children. No excuses.”¹ This notion—that through striving, anyone can achieve and create his or her own destiny—is central to American ideology. This ideology asserts that the United States is a meritocracy and that its citizens—regardless of the social stratum from which they start—should aspire to, and in fact can attain, the height of social and economic success described as the American Dream. American meritocracy, the claim goes, has liberated its citizens from old-world confines of class and heritage. President Obama personifies the promise of American meritocracy—an African American man in a country with a long history of racism, rising from very modest means. His presidency seems to demonstrate that the American Dream is indeed within anyone’s reach.

But what if belief in the American Dream can lead to poor health among African Americans? Compared with Whites, African Americans experience more morbidity and mortality resulting from economic and other inequalities.² Moreover, upward socioeconomic mobility does not always lead to

better health for African Americans.³ We propose that in the context of strong social barriers to success, especially racism, belief in meritocratic ideology may be detrimental to African American health.

We do not suggest that believing in the American Dream is ineluctably detrimental to all African Americans, nor do we suggest that such beliefs should be eradicated. Certainly, belief in meritocracy and the possibility of success through hard work and effort undergirds American optimism and attempts to achieve. Instead, we hope to problematize how public health researchers and policymakers understand meritocracy by looking at some of the less visible ways in which meritocratic ideology may jeopardize health and well-being. We introduce our ideas about the potential pathogenic effect of meritocracy and briefly discuss two mechanisms: individual, through the impact of stress and coping on health, and structural, through the impact of beliefs and values on policies. Figure 1 depicts some mechanisms through which meritocratic ideology may lead to poor health.

THE NATURE OF MERITOCRACY

Meritocracy has been described as America’s dominant ideology.⁴ Indeed, it is so dominant as to be hegemonic—to eschew it is un-American.⁵ America’s history and folklore are replete with ideas related to meritocracy, suggesting that individual agency and resilience will lead to economic success. For example, novelist Horatio

Alger’s stories envisioned America as a meritocratic republic where all personal and societal rewards were equitably bestowed. The rags-to-riches life trajectories enjoyed by his characters remain a seductive and affirming narrative in American culture. The American Dream is salient in our national consciousness,⁶ and for many, it serves as a powerful motivator to strive for success. Moreover, for African Americans, meritocratic ideology can lower perceived vulnerability to prejudice,⁷ providing a sense of hope. It is difficult to argue with the message of hope inherent in meritocratic ideology that is reflected, for example, in President Obama’s message to African American schoolchildren that they can create their own destinies.

Still, as Merton⁸ noted, there is often a disjuncture between America’s meritocratic values that promote aspiration for success and the opportunity structure—the social, economic, and political structures that make success possible. The problem is that opportunities are not equally distributed, and they are not allotted solely by meritocratic criteria. For example, racism serves as a strong barrier to African American’s achievement. Even if unintended, the promise of equality inherent in meritocratic ideology serves to elide racism. Indeed, Geronimus and Thompson viewed meritocracy as part of a broader set of racialized ideologies that undergird health disparities. They argued that ideologies that laud equality and personal responsibility imagine a “community of virtuous seekers of the

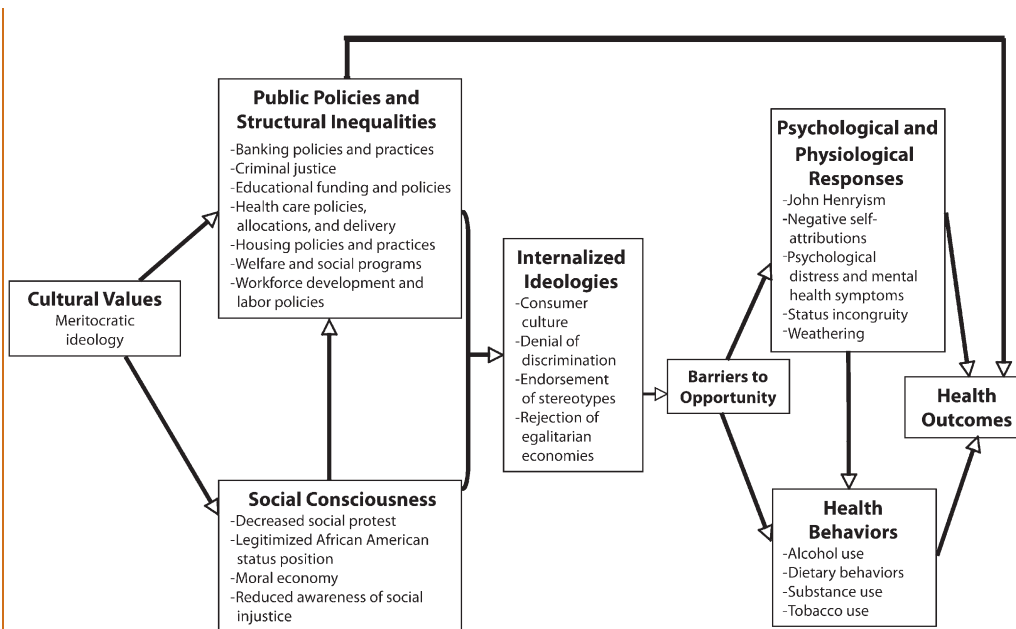


FIGURE 1—Structural and individual pathways through which meritocratic ideology may harm African American health.

A political climate guided by meritocratic ideology is related to general lack of support for social programs that assist those most in need. The American public's and policymakers' belief in meritocratic ideology catalyzes opposition to policies that contradict the idea that individuals deserve what they get and get what they deserve. For example, research shows that meritocratic ideologies influence opinions about how much governmental assistance should be provided to low-income women.¹⁵ Ironically, it is among the disadvantaged, who bear the brunt of inequalities, that system-justifying attitudes are often the strongest.¹³ In some studies, poor Southern African Americans were more likely than were their higher-income counterparts to endorse meritocratic notions that hard work leads to success.¹³ "Individuals who do not recognize that they are treated unjustly will not protest,"^{4(p342)} making agitation for equality less likely.

Thus, meritocratic ideology leads to policies that advance fewer allocations to help the disadvantaged, such as health care and welfare. Indeed, meritocratic ideology is associated with the endorsement of income inequality,¹³ which in turn is not only strongly associated with health but also associated with "the heart of problems which beset our societies and are constantly in the news."^{16(p1976)} Although meritocratic ideology may exert subtle and pervasive influence on American politics, support for social programs has varied across US history, and this variation is not necessarily coextensive with the cultural strength of meritocratic ideals. Strong social programs may be implemented even in a climate in which meritocratic ideologies are salient.

American Dream, people who work hard, play by the rules, and suffer the consequences if they don't."^{5(p252)}

Within this context, African Americans' demands for economic justice can be seen as unwarranted⁵; their lower economic and social standing is explained as individual failure rather than the effects of long-standing racism. These views are represented among some civil rights theorists. Traditionalists contend that post-civil rights African American capital deficiencies reflect African American cultural deficiencies, such as the rejection of mainstream culture, victimhood, and other self-defeating behaviors.⁹ They therefore eschew governmental remediation, essentially calling on African American people to "overpower strong environmental headwinds by dint of willpower."^{9(p34)}

MERITOCRATIC IDEOLOGY AND SOCIAL INEQUALITY

Meritocratic ideology imbricates the moral economy—the norms that govern economic activity and society's protections and privileges.¹⁰ Americans are conflicted about the inequality in their society and, hence, the need for and urgency of political action to promote equality.¹¹ When inequalities can be rationalized as inevitable outcomes of lack of talent, skill, or work ethic, inequalities in wealth and health can be justified as reflecting individual, not societal, failings.¹⁰

System justification theory illuminates the relationship between meritocratic ideology and political inaction, showing why even the most disenfranchised citizens view inequalities as necessary and even fair.¹² The theory, and related research, shows

that although the system is characterized by inequalities in access to resources, life chances, and life outcomes, believing that this is a just arrangement can be palliative. This reduces anxiety, dissonance, and perceptions of unfairness.¹² Among the disadvantaged, who bear the brunt of inequalities, system-justifying attitudes are often the strongest.¹³ Because meritocratic ideology promises everyone the chance to succeed, it diverts attention from structures and conditions, such as those related to racism, that make it impossible for many to succeed. This is not to say that individuals believe everything is fair; rather, they hold attitudes that are more positive toward the system than are warranted.¹⁴ Meritocratic ideology can obfuscate features of the opportunity structure that erect barriers to success.

Often, however, in the context of meritocratic ideology, social programs reproduce extant inequalities. For example, Franklin D. Roosevelt introduced the GI Bill (i.e., the Servicemen's Readjustment Act of 1944) to provide returning veterans unemployment pay while they looked for work; tuition allowances; and loans for homes, farms, or to start a business.¹⁷ Today, the program is hailed as legislation that transformed the United States by dramatically expanding higher education, housing and highway construction, and small businesses and, most important, by providing a gateway to the middle class for thousands of Americans.¹⁸ Supposedly, the GI Bill made good on core meritocratic ideals:

All those promises that brought people to our shores from the very beginning, that in this country there was opportunity to extend yourself to the limits of your ability. Education provided that opportunity for millions of people, made the promise of America real.¹⁸

But for African American veterans, the promise of the GI Bill was largely foregone. African American GIs were disproportionately and unfairly given dishonorable discharges, making them ineligible for GI Bill benefits. Those who were eligible were unable to translate their benefits into education or housing opportunities because the program operated through federal (e.g., Federal Housing Administration, Veteran's Administration) and private institutions (e.g., colleges, banks) that actively discriminated against them.¹⁷ Resultant inequalities in African American wealth and education levels are in turn used as evidence that African Americans are unable to compete in a meritocratic system.

Public discourse on home ownership and neighborhood quality has been punctuated by assertions that African American residents lack appropriate values, reflecting and reinforcing meritocratic ideology. Although some Whites agree that some individual discrimination exists, many remain skeptical that macrolevel policies and choices are discriminatory or that they harm African Americans. Contrary to evidence,¹⁹ they believe that the passage of civil rights laws has eradicated institutional level and systemic bias in the housing market.²⁰ Thus, Whites argue that negative features, such as crime, in predominantly African American neighborhoods reflect character deficits. As one White respondent said,

I think the majority aren't enthused, not motivated, and don't care. . . . The opportunity is there if they want to take advantage. I don't think most Blacks want to work for anything.²¹

Described as the cornerstone upon which African American–White health disparities are founded,²² racial residential segregation is a critical structural pathway through which meritocratic ideology harms health. Pre-civil rights bias continues to undergird stark differences in African American–White wealth,²³ but the US polity has been reluctant to recognize or remediate segregation and housing discrimination. The US Supreme Court ruled in 1992 to end a court-ordered integration program, holding that if resegregation was the result of private individual choices and not state action, there were no constitutional implications.²¹ Thus, meritocratic ideologies legitimize existing status differences and policies that harm health by locating the

responsibility for social status within individual characteristics.

MERITOCRATIC IDEOLOGY AND STRESS

Stress theory has been one of the core theoretical approaches to the study of health disparities in the United States, arguing that social and psychological demands can be taxing and lead to adverse health outcomes.²⁴ Meritocratic ideology may be a source of stress. If social status tends to be attributed to individual responsibility, meritocratic ideology may be associated with adverse health outcomes among African Americans by increasing the risk of internalizing negative self-attributions for failure to obtain the American Dream. To endorse meritocratic ideology—as most Americans do—means to be at risk for the psychic toll borne from perceptions about not measuring up. Alford Young's ethnography of poor African American men from Chicago's near west side²⁵ is particularly instructive in this regard. When asked if race was an important issue in American life, one participant responded, "It ain't important. . . . To me it's within the individual to get along. To me it's up to the person, you know. I don't think it's a racial thing."^{25(p143)} This exemplifies both meritocratic ideology and related system justification. If it's up to "the individual to get along," then society is exempt from the responsibility to remediate racial inequities.

Such denial of racism can have a harmful impact on health. Among working-class African American women and men, respondents who denied experiencing discrimination had higher blood pressure than did those who reported discrimination.²⁶ Similarly, denial of racial discrimination

vis-à-vis self-report and implicit assessment was associated with hypertension among African American respondents with less than a college degree.²⁷ These paradoxical findings may indicate that individuals who can express their experience with racism face lower health risks than do individuals who internalize it.²⁶ If meritocratic ideology subverts the recognition and articulation of racial inequality, rather than acting as a source of uplift, it may in fact place individuals at risk.

Meritocratic ideology may also be associated with adverse health by increasing health-damaging, high-effort coping to overcome adversity. Evidence suggests that in low status groups, the endorsement of meritocratic ideology can lead to self-blame for failure to reach a goal instead of attribution of discrimination. Research on John Henryism, a term inspired by the story of John Henry, the steel-driving man who collapsed after competing with a high-powered machine, shows that persistent high-effort coping in the face of impediments to success can lead to hypertension among African Americans from low socioeconomic backgrounds.²⁸ Meritocratic ideology may be an important catalyst for John Henryism by increasing the propensity for single-minded determination to succeed and increasing self-blame and demoralization.

CONCLUSIONS

The association of meritocratic ideologies with poor health for African Americans has implications for public health and health policy. The World Health Organization sees health equity as actionable through social and economic policy interventions.²⁹

Three overarching recommendations are to (1) improve daily living conditions; (2) tackle the inequitable distribution of power, money, and resources; and (3) measure both the extent of health inequities and the impact of policy and action. At the heart of the second aim is a call to address inequities in the way society is organized.²⁹ To do that requires recognizing that societal structure is not simply the reflection of variation in individual talents and effort, as suggested by meritocratic ideologies.

To accomplish significant changes, we must broadly define health policy as encompassing a range of governmental policies, including labor, education, and transportation.³⁰ For example, educating American youths about inequality—given that many Americans are not aware of social disparities and the means by which they are perpetuated³¹—is not just good pedagogy, it is indirectly health policy. African American parents socialize their children to negotiate their social world from a position of psychological strength, self-efficacy, and optimism while remaining cognizant of the inequality they are likely to face. So too must the United States socialize children to attend to long-standing disparities in the distribution of resources and life chances. Again, the goal is not to quash the American Dream for US youths but to discourage uncritical acceptance of a deeply held but vexed cultural value. A steadfast belief in the United States as the land of opportunity may be as hazardous as it is inspiring. The American Dream remains central to America's sense of self, but as Langston Hughes asks, "What happens to a dream deferred?"^{31(p426)} ■

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References

1. The White House. Remarks by the president to the NAACP centennial convention; 2009. Available at: http://www.whitehouse.gov/the_press_office/Remarks-by-the-President-to-the-NAACP-Centennial-Convention-07/16/2009. Accessed March 11, 2010.
2. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health*. Washington, DC: National Academies Press; 2003.
3. Colen CG, Geronimus AT, Bound J, et al. Maternal upward socioeconomic mobility and Black-White disparities in infant birthweight. *Am J Public Health*. 2006;96(11):2032-2039.
4. McCoy SK, Major B. Priming meritocracy and the psychological justification of inequality. *J Exp Soc Psychol*. 2007; 43(3):341-351.
5. Geronimus AT, Thompson JP. To denigrate, ignore or disrupt: racial inequality in health and the impact of a policy-induced breakdown of African American communities. *Du Bois Rev*. 2004;1(2):247-279.
6. Kamp D. Rethinking the American dream. *Vanity Fair*. Available at: <http://www.vanityfair.com/culture/features/2009/04/american-dream200904?printable=true¤tPage=all>. Published April 2009. Accessed June 11, 2010.

7. Major B, Kaiser CR, O'Brien LT, et al. Perceived discrimination as worldview threat or worldview confirmation: implications for self-esteem. *J Pers Soc Psychol*. 2007;92(6):1068-1086.
8. Merton RK. Continuities in the theory of social structure and anomie. In: *Social Theory and Social Structure*. Glencoe, IL: Free Press; 1957:215-248.
9. Brooks R. *Racial Justice in the Age of Obama*. Princeton, NJ: Princeton University Press; 2009.
10. James SA. Confronting the moral economy of US racial/ethnic health disparities. *Am J Public Health*. 2003;93(2):189.
11. Hochschild JL. Ambivalence about equality in the United States or, did Tocqueville get it wrong and why does that matter? *Soc Justice Res*. 2006;19(1): 43-62.
12. Jost J, Pelham B, Sheldon O, et al. Social inequality and the reduction of ideological dissonance on behalf of the system: evidence of enhanced system justification among the disadvantaged. *Eur J Soc Psychol*. 2003;33:13-36.
13. Jost JT, Banaji MR, Nosek BA. A decade of system justification theory: accumulated evidence of conscious and unconscious bolstering of the status quo. *Polit Psychol*. 2004;25(6):881-919.
14. Napier JL, Mandisodza AN, Andersen SM, et al. System justification in responding to the poor and displaced in the aftermath of Hurricane Katrina. *Anal Soc Issues Public Policy*. 2006;6(1):57-73.
15. Appelbaum LD, Lennon MC, Aber JL. *Public Attitudes Toward Low-Income Families and Children Research Report No. 2: How Belief in a Just World Influences Views of Public Policy*. New York, NY: National Center for Children in Poverty; 2003.
16. Wilkinson RG, Pickett KE. The problems of relative deprivation: why some societies do better than others. *Soc Sci Med*. 2007;65:1965-1978.
17. Cohen LA. *Consumers' Republic: The Politics of Mass Consumption in Postwar America*. New York, NY: Knopf; 2003.
18. Lehrer J. Remembering the GI Bill: A NewsHour With Jim Lehrer Transcript. July 4, 2000. Available at: http://www.pbs.org/newshour/bb/military/july-dec00/gibill_7-4.html. Accessed March 12, 2010.
19. Massey D, Lundy G. Use of Black English and racial discrimination in urban housing markets. *Urban Aff Rev*. 2001; 36(4):452-469.
20. Farley R, Steeh C, Jackson T, et al. Continued racial residential segregation in Detroit: 'chocolate city, vanilla suburbs' revisited. *J Housing Res*. 1993;4(1): 1-38.

21. Krysan M. Community undesirability in Black and White: examining racial residential preferences through community perceptions. *Soc Probl*. 2002;49(4): 521-543.
22. Williams DR, Collins C. Racial residential segregation: a fundamental cause of racial disparities in health. *Public Health Rep*. 2001;116(5):404-416.
23. Shapiro TM. *The Hidden Cost of Being African American: How Wealthy Perpetuates Inequality*. New York, NY: Oxford University Press; 2005.
24. Clark R, Anderson NB, Clark VR, et al. Racism as a stressor for African Americans: a biopsychosocial model. *Am Psychol*. 1999;54(10):805-816.
25. Young AA. *The Minds of Marginalized Black Men*. Princeton, NJ: Princeton University Press; 2004.
26. Krieger N, Sidney S. Racial discrimination and blood pressure: the CARDIA study of young Black and White adults. *Am J Public Health*. 1996;86(10):1370-1378.
27. Krieger N, Carney D, Lancaster K, et al. Combining explicit and implicit measures of racial discrimination in health research [published online ahead of print Nov 17, 2009]. *Am J Public Health*. doi:10.2105/AJPH.2009.159517.
28. James SA, Keenan NL, Strogatz D, et al. Socioeconomic status, John Henryism, and blood pressure in Black adults. The Pitt County Study. *Am J Epidemiol*. 1992; 135(1):59-67.
29. Davies M, Adhead F. Closing the gap in a generation: health equity through action on the social determinants of health. An international conference based on the work of the Commission on Social Determinants of Health, 6-7 November 2008, London. *Glob Health Promot*. 2009;(suppl 1):108-109.
30. Williams DR, Jackson PB. Social sources of racial disparities in health. *Health Aff*. 2005;24(2):325-334.
31. Rampersad A, Roessel D, eds. *The Collected Poems of Langston Hughes*. New York, NY: Knopf; 1994.

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