Embodying good citizenship and success in migration

Aging Filipina migrants talk about health

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Introduction

The population's health, a major area of concern in biopolitics (Foucault 2008), figures prominently in studies of the movement of individuals from one population to another and in studies of aging populations. Many studies on aging, whether mainstream or more critical, feature health as a major issue. Health is associated with the well-being of elderly persons (Bolzman et al. 2004; Pool et al. 2009; Hodes and Suzman 2007), seen as the source of a potential economic and political crisis for states (Cruickshank 2003; Davey and Glasgow 2005; King 2006), as growing more medicalized and yet also more individualized (Pond, Stephens, and Alpass 2010; Slevin 2010; Joyce and Mamo 2006; Higgs 1997; Faircloth 2003), and as producing new subjectivities in contemporary society (Crawford 1980; Novas and Rose 2000; Rose 2003). Migrant studies also often feature health as a concern as it is a basis for acceptance as a migrant (Immigration NZ 2012), thought to impact on migrants' well-being and supposed ability to contribute to the host country (Malmusi, Borrell, and Benach 2010; Salant and Lauderdale 2003), and is taken as an indicator of adjustment to migrant life (Dean and Wilson 2009; Chen, Smith, and Mustard 2010; Tsai 2013). Within these two areas exists the intersection where the health of *aging* migrants is brought into focus, where the particular challenges and opportunities that aging migrants face in the area of health are investigated (e.g., Bolzman et al. 2004; Cichello and Thomas 2003; Dial 2007; DiPasquale-Davis and Hopkins 1997; Lomiwes 2006; Mui and Kang 2006).

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This paper is about aging migrants' understandings of health, as it is crafted within more widely available discourses related to it. I regard health as having meanings that are »deeply personal and therefore infinitely varied« (Crawford 2006, 404), and yet as socially shared and produced (Estes and Binney 1989). In particular, I focus on older Filipina migrants' ideas about how a healthy body is achieved, and what it means to them as migrants to New Zealand. I will establish links between these and the literature on the medicalization of health and responsibilization in aging and argue that participants' association of healthy practices with consumption can be used to build a narrative of success in migration.

The preponderance of migrant studies in psychology which focus on the individual as the site of problems (e.g., in acculturation, stress, physical and psychological health) and of solutions (e.g., training, better/more accurate information, individual coping mechanisms) contributes to the systemic oppression of large groups of migrants (e.g., those of non-white ethnicity, those who are aging, those who are not highly educated or skilled) in their propensity for ignoring structural sources of migrants' marginalization. In focusing attention on the how these structural forces can operate at the level of the individual, my study is aligned with feminist, embodied, critical approaches to the study of aging and migration in psychology. An embodied approach has great political and theoretical potential as it makes visible the invisible and allows connections to be made between macro and micro, global and local, social structures and individual bodies.

First, a brief backgrounder on Filipino migration; second, a discussion of relevant discourses around aging and health; third, an explication of the material-discursive approach to embodiment that I take; next, methodology of the study; and lastly, evidence from the field showing links between individual subjectivity and these public discourses.

Filipino migration

The Philippines is now into its fifth decade of using labor outmigration as a national economic strategy. Presidential Decree 442, issued in 1974, marked the Philippine government's first clear involvement with Filipino

labor export (Battistella 1999; Guevarra 2009). P.D. 442 aimed to promote overseas employment and ensure »the best possible terms and conditions of employment« (*P.D. 442 Labor Code of the Philippines* 1974, art. 17.2) through the establishment of government agencies which served as official channels for the recruitment and hiring of all land-based and sea-based overseas workers. In 1978, government policy shifted from favoring government-to-government management of overseas labor to privatization of recruitment, with the government acting in a more supervisory and regulatory role (Battistella 1999). This trend toward privatization culminated in the Migrant Workers and Overseas Filipinos Act of 1995 (RA 8402), which reflects the economic liberalist thinking of the time. From this point onward, the state has claimed that it no longer promotes overseas employment but instead »*manages* labor migration by supporting the desires, choices, and freedom of Filipinos to work overseas« (Guevarra 2009, 23; emphasis in original). As of December 2012, an estimated 10.49 million Filipinos were living and working in over 200 countries across the globe (Commission on Filipinos Overseas 2012). Many of these individuals are aging in the countries where they now work and reside; and while scholarship on Filipino migration is significant within the larger arena of migration studies, little attention has been given to aging Filipino migrants.

The Philippine government's labor migration program has been critiqued by scholars as producing Filipinos as naturally inclined to work overseas. In emphasizing individual responsibility, freedom, and choice, the state and employment agencies together are able to discipline Filipinos to »fulfil the goal of producing ›responsible‹ (that is, economically competitive, entrepreneurial, and self-accountable) and therefore, ideal workers and global commodities« (Guevarra 2009, 8). Migrants are represented as being autonomous, knowledgeable, and empowered agents who act rationally in their own best interest (Tyner 2004). These analyses echo concerns that globally, economic and overall well-being is coming to be seen as something to be secured at the individual level rather than achieved through collective action or state intervention to mitigate the effects of globalization (Inouye 2012). Such a view of well-being is situated within

a larger discourse of empowerment that constructs a neoliberal subject who is not only self-reliant, but free and autonomous from systems of oppression (Inouye 2012).

A new aging

Since the 1960s, there has been a clear shift in the discursive construction of retirement in policy, academic, and media texts in the West; representations of social isolation, structured dependency, lack of roles, and passivity came to be replaced by portrayals of later life as a time of opportunity, continued productivity, self-fulfillment, and self-reliance (Rudman 2006). It was during this period of transition that the book *Feminine Forever* was published in 1966 by American gynecologist Robert Wilson, who described menopause as a curable and preventable disease. In 1998, *Successful Aging* (Rowe and Kahn) presented what was then an alternative narrative (to the one of disease and decline) of aging. Both of these books were written for and popularly received by a lay audience, garnering wide attention in the media and among professionals, and shaping both public and academic debates and even research and publication agendas (Houck 2003; Holstein and Minkler 2003). In the US, this period also coincided with the rise of youth culture and consumerism that brought attention to the body as a site for expressing and/or enhancing self-identity (Gilleard and Higgs 2013; Giddens 1991). Fashion and cosmetics advertising eventually marketed the idea of extending the image of youth in later life, challenging established stereotypes on aging and opening up the possibility of »not having to become old on other people's terms« (Gilleard and Higgs 2013, 28). Both empirical studies on the media (Rozanova 2008; Rudman 2006) and public opinion polls on older people (Andrews 2009) suggest that these discourses have grown within the public's consciousness and so have come to define a new »norm« in aging.

Rowe and Kahn's (1998) *Successful Aging* identified three components of successful aging: avoiding disease, maintaining cognitive and physical function, and sustaining engagement with life. The body, therefore, is an important locus for demonstrating this »new aging,« an active site where the battle against aging is fought. And indeed, it is a fight that involves

increasing amounts of work over time. Within this new aging, there is a strong emphasis on good health and activity, which means that staying fit (or at least appearing fit) is highly valued social capital.

The emergence of a public health discourse that emphasizes public surveillance and identification of risks, and the significance placed on food as an expression of identity and »agency« (e.g., as a »health-conscious« person) are some of the contexts in which this new aging is conceptualized and practiced (Gilleard 2002). Individuals are more vigilant for outward signs of ill health, with the signs of aging now being taken as signs of ill health (Gilleard 2002). However, the »will to health« has come to mean more than just avoiding sickness or premature death, now also »encod[ing] an optimization of one's corporeality to embrace a kind of overall »well-being«—beauty, success, happiness, sexuality and *much more*« (Rose 2001, 17; emphasis MO). This preoccupation with health and its moralization is referred to by Crawford (1980, 2006) as healthism. He argues that health has become a »super-value,« expanding the concern for health beyond the medical and into more holistic notions of wellness and success, defining good citizenship and positive personal identities (Crawford 2006). In the context of increasing political and economic instability, self-control in and self-responsibility for health can have important symbolic value among the middle class even though assiduous efforts to prevent illness and promote fitness cannot guarantee perfect health (Crawford 2006).

Although highlighting the body's malleability supports alternative ways of being in an aging body, the probability of a responsible individual occupying such alternative spaces through consumption is limited by the accumulated impact of a lifetime of oppressions (e.g., discrimination due to race, gender, immigrant status, health status). Underlying this new aging, then, is a »new ageism« (Holstein and Minkler 2003) which insists that aging depends mostly on individuals' own efforts (Cruickshank 2003) and therefore marginalizes and stigmatizes those individuals who are unable to achieve »successful aging.«

A material-discursive approach to the aging migrant's body

In the last two decades, scholars have begun to take interest in studying aging as a socially constructed experience (e.g., Hepworth 2003; Cruickshank 2003; Gilleard and Higgs 2000; Bernard, Chambers, and Granville 2000). Although such views of aging and the aging body have been fruitful for investigating how social structures produce the marginal position and difficult realities many aging individuals face today, they fail to account for the difference that material bodies make for each individual. Some bodies are more ill than others, some bodies look older than others of the same age, and bodies respond to health supplements, medical intervention, and exercise differently; these physical differences are just as significant for producing different experiences of aging as the various configurations of discourses around aging and migration. What this implies is that the aging body cannot be seen as an entirely »docile« body. While its docility may be the objective of discipline (Foucault 1977), it is apparent, given the changes it undergoes, that the aging body is a decidedly *unruly* body, constantly changing and increasingly difficult to *fix*, in the many senses of the word. For, certainly, the task given to aging individuals in contemporary society is to not age—to »fix« (read: secure or keep in position, but also repair, correct, manipulate) their bodies and keep them from changing.

This paper follows the recent trend of focusing on embodiment in aging studies (e.g., Clarke and Griffin 2007; Twigg 2004; Joyce and Mamo 2006; Marshall and Katz 2006) and migration studies (Dunn 2010). I adopt a material-discursive approach (similar to that in Ussher 1997) which recognizes the aging migrant's body as both material and socially constructed. As Shilling (1993, 12) notes, there are »certain limits« to how the body can be transformed by its entry and participation in society. That these limits exist, and that they are *physical* limits, is never more apparent than in aging. Bodily changes over time, both external and internal, all become the signs by which an aging body is known (Laws 1995). What they imply, how individuals feel, and what they do in response (which may have a material impact on the body) are meaning-making

activities that are carried out in the context of varying and multiple discourses around aging and being a migrant.

Adopting such an approach, which recognizes both the body's physicality as well as its constructedness, brings attention to the physical realities of aging as experienced by individual women, without ignoring how the economic, social, and political conditions surrounding them (e.g., as transnational citizens who have varied economic, social, and discursive resources to draw from) impact on these realities. It takes into consideration cultural representations of migrants and of older persons that form the matrix of discourses within which meaning is crafted and negotiated. By doing so, I provide an analysis that links power and discourse to material bodies and individual realities, in keeping with Foucault's (1980, 57) assertion that »nothing is more material, physical, corporeal than the exercise of power.«

Methodology

This study utilized two forms of critical psychology for its methodological framework—*Sikolohiyang Pilipino* (indigenous Filipino psychology) and feminist psychology. As critical psychologies, *Sikolohiyang Pilipino* and feminist psychology share the following principles: that research is political; that language is a bearer and producer of culture and ideologies; that context and culture are crucial to understanding individuals; and that the power gap between researchers and participants must be addressed (Fox, Prilleltensky, and Austin 2009; Denzin and Lincoln 2008; Paredes-Canilao and Babaran-Diaz 2011). Critical psychologies are interested in power—how it operates and how it is used by, for, and against individuals (Prilleltensky and Nelson 2002). Both *Sikolohiyang Pilipino* and feminist psychology have extensive critiques of how psychology has been used to oppress specific groups of people (e.g., women, the Filipino underclass).

Data gathering

The indigenous Filipino method *pakikipagkwentuhan* (Orteza 1997), similar to a semi-structured interview, was employed for this study. This method is akin to other narrative methods often used in qualitative studies interested

in subjective accounts and meaning rather than verifiable »facts« (Hugh-Jones 2010). It involves conversation between individuals (ranging in number from two to seven, or even more[1]) who are free to participate in telling stories when, where, and in whatever manner they feel is appropriate. This method, first named and used as a method of inquiry in the mid-1970s (de Vera 1995) during the beginnings of the move toward indigenization in psychology in the Philippines, was developed as one of several techniques that were more participatory and more sensitive to Filipino culture (Orteza 1997; Javier 2005). Since then, it has undergone critique and revision over several decades and remains one of the more widely used of several culturally-based data-gathering methods. While *pakikipagkwentuhan* is not necessarily unique[2] as a method, its utility lies in its familiarity and embeddedness in Filipino culture and practice. In comparison to an interview, which may have formal, evaluatory connotations, *pakikipagkwentuhan*, as it is developed from existing patterns of behavior in Filipino culture (Santiago and Enriquez 1976; Pe-Pua and Protacio-Marcelino 2000), enables a more informal, relaxed encounter.

Participants were recruited through personal and formal networks, distribution of flyers at a church attended by Filipinos, and invitation through a Filipino radio show. Criteria for inclusion were: age (50 and above), number of years living in New Zealand (at least five years), and location (all based within Auckland, the most populated city in New

1 According to naturalistic observations of pakikipagkwentuhan as it occurs in community settings, 15 and sometimes even more (Javier 2005).

2 In fact, Orteza (1997, 2) claims that pakikipagkwentuhan is a natural everyday practice »not only among Filipinos but also among different races, ages, sexes and cultures« (transl. MO). I will be presumptuous and suggest that the korero mai approach, an interview procedure discussed by Graham Smith in New Zealand, which allows participants in a family court study »to tell their stories in their own way« (Swadener and Mutua 2008, 41), is of a similar nature. Another example, from Chinese culture, is the fangtan interview method which features flexibility, more equitable power relations between interviewer and participant, »insider« status of the interviewer (meaning the development of trust and openness), and the use of the Chinese language (Li 2011).

Zealand and where the majority of Filipino migrants may be found). The effort to include as diverse a group as possible within these limits led to the inclusion of two participants who were 49 years of age at the time of the first interview. In the end, *pakikipagkwentuhan* was conducted with 20 Auckland-based Filipina migrants from 49 to 69 years of age, eliciting stories about coming to New Zealand, bodily changes over time, and thoughts about their future. These sessions were audio-recorded and transcribed. Consistent with the flexibility of *pakikipagkwentuhan*, both the content and the process accommodated the participants' additions (e.g., topics outside of those initially listed, introduction of photos and other materials into the conversation), questions (e.g., about the researcher's migration status, work, family), and constraints.

Data analysis

I used thematic analysis (Braun and Clarke 2006) together with a poststructuralist approach to language in order to investigate links between social institutions, language, and individual subjectivity. A poststructuralist approach to language means that language is not taken to provide access to an individual's internal state or disposition, nor to be a reflection of an external, objective reality; instead, language is regarded as constitutive of one's subjectivity and reality (Wetherell 1997; Weedon 1997; Gavey 1997). What this implies is that individuals (say, aging Filipina migrants) do not exist »objectively« outside of history and culture, but instead are constituted in discourse (e.g., in media, in political debates, and in popular, everyday discourse) at a specific moment and place. An interest in language means an interest not in accessing *the* truth that talk is presumed to provide, but in *a* truth crafted within a particular context for a particular purpose.

Within this view of language and power, subjectivity or our sense of self is constructed in and through language (Weedon 1997; Foucault 1972). Individuals, rather than having a fixed identity or »essential« self, occupy different subject positions made available to them by the cultural repertoire of discourses so as to manage their moral location within social interaction (Arribas-Ayllon and Walkerdine 2010). Participants' responses, therefore,

are seen as products of: 1) cultural resources or discourses that shape subjectivity (rather than an expression of ideas, memories, or dispositions »extracted« from individuals) and 2) their capacity for making sense of their experiences and for negotiating their own agency and constraints. Participants' responses were not evaluated for their accuracy or truthfulness. Their utility was in their representing *a* reality—that they were meaningful to the participants and shaped their conduct in some way. In the analysis, I was interested in participants' efforts at presenting a coherent story and subjectivity, considered cultural resources that resonate with the discourses they oriented to in their construction of their accounts, and paid attention to variations across participants' material and discursive »realities.« In what follows, participants' accounts of their health as older persons in New Zealand will be discussed as being shaped by the broader discourses on aging, health, and migrant Filipinos.

About the participants

All except three had immediate family residing in New Zealand at the time of the *pakikipagkwentuhan*. All except three live alone (two of whom had no family residing in New Zealand). Nearly all (18/20) were working, although three of these were only working part-time at the time of the interviews. All participants described themselves to be in relatively good health, although some had chronic illnesses (e.g., hypertension, diabetes) that required medication and monitoring, and a few (3/20) were cancer survivors. The sample had a higher proportion of those with higher education and higher labor force participation rate compared to Filipinos in general (according to the most recent census[3]), and did not include

3 Although Filipinos are among the most highly educated group of overseas-born individuals in New Zealand (Statistics New Zealand 2014, 1999), the proportion of participants with a university degree (70%) is far higher than the 42.5% of Filipinos (male and female) who reported they had a bachelor's degree or higher in the 2013 census (Statistics New Zealand 2014). Ninety percent of the participants were in the labor force—a larger proportion than the 75.6% of all Filipinas above 15 years of age who were in the labor force during the 2013 census (Statistics New Zealand 2014).

those who were very ill, those who needed assistance with daily living, those in care homes, and those who were occupied caring for an ill spouse or other family member. The sample then, was unable to capture the experiences and meanings arising from these more difficult circumstances especially relevant for discussions of health. That said, I propose that these participants' claims and arguments around health are familiar to (if not common among) Filipino migrants in Auckland as they do share some important similarities with this community—they spent a significant number of years in the Philippines, are part of the Filipino community in Auckland, and maintain ties to their families and home communities in the Philippines.

Producing the healthy, elderly New Zealand citizen

Although I did not ask participants to talk specifically about health, the topic came up repeatedly when they discussed bodily changes and plans for or worries about the future. All participants pointed to health as an important concern or preoccupation, and spoke of various health-promoting products, services, or activities they had or engaged in regularly. Common in participants' stories about health and aging is the idea that New Zealand offers opportunities for enjoying a healthy life. I will argue that aging migrant Filipinas idealize the elderly New Zealander as an exemplar for independent, healthy aging, and that they use their own health to signify success in migration by constructing healthy aging as a norm in New Zealand and pointing to state support as enabling healthy aging. I will situate this discussion within larger conversations about regulating the aging body, the links between health surveillance and good citizenship, and the neoliberal, consumerist ethic that frames them.

The elderly New Zealander as an ideal

Among the participants' stories, strong positive regard for the image of the busy, independent elderly New Zealander was a common theme. For example:[4]

4 The names of all participants have been changed to protect their identities.

> Liz: I actually have two [older people] in my department, one is 72, still working, one is 67, still working. They're the ones who keep going on holiday because their life is already established. […] But you know what, the white [people] here, even when they're in a rest home they have lots of activities still, they have bus, group, um, they go all to kinds of places.
>
> Gab: Their culture is different […] They're so independent. I have one colleague there who's divorced from her husband. […] So, she lived for many years by herself. And she raised her children. And her child is over 30 years old now. […] She has grandchildren. But, they're alone. I said, this one's so brave. (Chuckles). Alone in her home. And also, I've seen those retired, living in their own homes alone. For how many years now.

Elderly New Zealanders were portrayed in these accounts as enjoying an active, independent lifestyle in older age and were described in positive terms: »established,« »brave,« »independent.« This image of the elderly New Zealander is consistent with the ideals of »positive« or »successful« aging (Andrews 2009; Öberg 2003) embodied by »modern retirees« whose choices determine the quality of their aging (Rudman 2006) and which is reflected in New Zealand's policy on positive aging[5] (Ministry of Social Development 2007; Davey and Glasgow 2005). The image is supported to some degree by statistical data: according to some studies, an increasing number of New Zealanders are working beyond the age of 65 (Hurnard 2005; Ministry of Social Development Office for Senior Citizens n.d.) and over 90% of New Zealanders aged 65 and older are living in private dwellings (Ministry of Social Development 2007). Independent life expectancy has improved significantly in the last decade, which the New Zealand state attributes to increased access to health care and to »people *choosing* healthier lifestyles« (Ministry of Social Development Office for Senior Citizens n.d., 34; emphasis added).

5 The New Zealand positive ageing strategy. Positive ageing indicators 2007.

However, there is also great disparity among aging individuals' well-being, based on ethnicity, gender, marital status, and socio-economic status. More likely to be disadvantaged in old age are women, the poor, ethnic minorities, the unmarried, and the widowed (Ministry of Social Development 2007; Waldegrave and Cameron 2009; see Fergusson et al. 2001). While many New Zealanders appear to be enjoying an active, healthy, relatively independent lifestyle, such a lifestyle should be understood to be a product not (only) of individual choice but of systematic inequalities that privilege some groups at the expense of others. According to other studies (Davey and Glasgow 2005; Rudman 2006), the emphasis on individual responsibility marginalizes individuals who are unable to fulfil the directive to stay healthy, active, and independent. Indeed, the reality of the diversity in the actual living conditions of older New Zealanders—the one in two who suffer from some form of disability, those who live outside the 12 big cities in New Zealand and have little or no access to public transport, and those who are not of European ancestry (particularly Māori) and who are more likely to have a disability (Ministry of Social Development 2007)—was left almost entirely unarticulated among participants' accounts.

In participants' accounts, the active, elderly New Zealander was held as an exemplar of how aging is »done« in New Zealand; participants' decisions and desires related to their own health and aging were made and evaluated in relation to it. Liz, for instance, expressed the above idea in the context of explaining that she wanted to continue working and living independently for as long as she could, linking work, activity, and healthy aging together by saying, »You'll grow weaker and die earlier if you're not active.« Despite having identified racial discrimination[6] as an issue in the workplace in her narrative and having experienced job insecurity which she understood as bringing about her physical and mental health issues, Liz framed healthy, active (and employed) aging as a matter of choice. On the other hand, Gab spoke of elderly people she

6 Participants' experiences of and constructions of discrimination in migration are discussed in a separate paper (Ong 2016).

knew when she talked about not wanting to impose herself on her children in the future. Gab expressed some distress over this, as she also desired to live with (or close to) her children in her old age and yet worried about becoming a burden to them; she worried about not being as »brave« as elderly New Zealanders who lived alone in their homes. These suggest that the idealization of the (inaccurate) image of the active, healthy, elderly New Zealander has real consequences for migrant Filipinas; it compels them to achieve such an ideal even when their own material circumstances as individuals, as women, and as non-white migrants are different, and can lead to distress or a sense of failure when they do not.

What makes healthy, active, and independent aging possible? Participants view New Zealand as *enabling* positive outcomes for its older citizens through a supportive culture and state.

A New Zealand culture of health

A number of participants commented that the lifestyle and culture in New Zealand were conducive to pursuing health in aging. Even while participants identified many different sources of stress in their own lives (work, care work, relationship issues, loneliness, etc.) several generalized that the New Zealand lifestyle is less stressful than that in the Philippines, and that it had a positive impact on their health.

In the Philippines, Gab lived and worked in a small urban center in one of the regions outside the capital. Her husband was also employed and they had three young children cared for by domestic workers. In New Zealand, she found employment in the same profession and lived together with her husband and two unmarried, adult children at the time of the *pakikipagkwentuhan*. In the excerpt below, Gab asserts that the New Zealand lifestyle is more relaxed and is part of the reason for the *possibility* of better health, a common claim made by other participants:

> Gab: That's [the hypertension's] because of the stress at work when I was in the Philippines. But, at the same time, it's probably also because of the lifestyle. I'm always sitting, working and working, and the stress of the job when I had deadlines.

> Interviewer: Does it mean that, even here, your situation is similar— the level of stress, the sedentary lifestyle and such?
>
> Gab: It's more relaxed here [in New Zealand] than there [in the Philippines]. And also, there, it's possibly also the surroundings. I can't breathe properly there. It's like […] the change of temperature— you're always in an air-conditioned room, then when you go out, it's so hot. Maybe that's one of the things that affected me. Here, there's also a change of winter, summer (laughs) that we don't have there. But, it seems more relaxed, the lifestyle here. And if say, I choose to really, say, take advantage of what [New Zealand] has to offer, I should be healthier.

Participants described life in New Zealand as »happy,« »relaxed«— echoing findings from a study on sexual health where participants characterized New Zealanders as being a »laid back people« (Braun 2008, 1821). The relationship between stress and health, while contentious (Mulhall 1996; Pollock 1988), currently dominates both lay and scientific discourse (Donnelly and Long 2003). And while studies on stress and migrant or elderly health suggest that life as a migrant and an elderly person can be full of stresses (related to finding employment, adjustment, dealing with discrimination, loneliness, loss of status etc.), the participants' accounts are notable for their assertion that life in New Zealand is less stressful and therefore produces better health outcomes.

To suggest that the lifestyle and culture in New Zealand are conducive to good health in aging is to suggest that this is a more easily achievable norm in New Zealand, but also to homogenize it and erase the existing variation and the discrimination that produces those variations. The construction of lifestyle and culture as enabling health shapes participants' expectations for their future, their practices, and their understanding of themselves should they fail to achieve health. As a result of such a construction, Gab blamed mainly herself for failing to »choose« to »take advantage« of the health-promoting lifestyle that is characteristic of New Zealand:

> So, when I feel something in my body, I know it's because I don't exercise. […] all the resources are there. If I want to walk I can go to the park, or even by the road, I can walk. […] you have many reasons why you don't do that, but you know they're just excuses.

This construction of health as being a normal and expected outcome of life in New Zealand promotes the idea of health as, paradoxically, an effect of individual efforts at adopting New Zealanders' lifestyles and/or minimizing stresses from other sources. Critical literature on the discourse of stress suggests that it promotes naturalism, individualism, rationalism and objectivity, and downplay the role of social context in health (Donnelly and Long 2003). Stress is naturalized in that it is seen to be part of nature, rather than society, and somatized in how it is localized in individual's *bodies* rather than in their *social relationships* (Young 1980). Individuals are tasked to »cope« with stress to produce good health outcomes; this coping is constructed to be achievable through rational, objective decision-making about one's lifestyle and the knowledge or advice health professionals provide individuals (Donnelly and Long 2003). The accounts given above appear to contradict these analyses. Whereas they do locate stress within a larger socio-cultural context, in asserting that social conditions and cultural norms in New Zealand *already* encourage healthy aging, individuals (such as Gab) who are somehow unable to produce or display a healthy body in aging risk bearing the blame for being unable or unwilling to make the most of a health-enabling environment.

Enjoying the fruits of migration: State-supported healthy aging in New Zealand

Other than an enabling culture and environment, most participants identified the New Zealand government as supporting services that allow its citizens to enjoy healthy aging:

> Vangie: The government looks after everyone here, yes. If you can't go to the market, someone will go to the market for you here. For example, if you're really, really old and you can't do it anymore. If you're sick the district nurses here will visit you. Yes.

> Like say, if I want to go to the doctor, it's right over there, really close. And I don't need to pay the bus fare or anything. And if I want to go to the [a particular] clinic someone will pick you up, someone will take you there. […] So what else could you want in your life? In the Philippines no one will do that for you, right? Even if you say you have maids there, but it's still not like here where they look after you.
>
> Ela: Well, here, everything is free. So, why not [do the pap smear annually]? You're just going to lie down, just open your legs. (laughs) There's nothing to pay for. Unlike in the Philippines. I mean, you know, are you going to wait until something's wrong with you?

Remarks such as these contrasted an inadequate publicly funded health service in the Philippines with what is sometimes portrayed (as in Vangie's account) as a *more than adequate* health care service in New Zealand. In making these exaggerated claims (in claiming »everything« is provided, is free, and in asking rhetorically, »What else could you want in your life?«), these women effectively positioned all possible barriers to good health as removed and that, therefore, only the irresponsible willfully flout medical advice and refuse these services. In these accounts, alongside claims that the New Zealand state »looks after everyone,« is a strong responsibilization for health; individuals are admonished *not to waste time* (Ela: »[…] are you going to wait until something's wrong with you?«) and to understand that they have no excuses not to prioritize health and prevention.

Good health is not enjoyed by *all* New Zealanders, nor by *all* the participants. Vangie suffered from diabetes and its complications, while Ela had had cancer which required surgery and treatment and was in remission at the time of the *pakikipagkwentuhan*. Several other participants had similar conditions. And yet, despite the varied health issues they suffered from as they grew older in New Zealand, all participants claimed that health in aging was more likely to be achieved in New Zealand than in the Philippines because of the perceived greater accessibility and affordability of health care in New Zealand. An oft-repeated concern among the

participants was, *if* they chose to go back home to the Philippines, and they fell ill, »when your money runs out, what will happen to you?« (Liz).

I do not suggest that the reality of the health service disparities between New Zealand and the Philippines do not exist, nor that the claimed better health outcomes for those who are able to access these services in New Zealand are *only discursive*. The treatment Vangie and Ela received from New Zealand's health care services are certainly valuable and make real and perceived differences in their bodies and everyday lives. My contention is that there is, among these accounts, a strong version of what has been called a »no legitimate dependency« discourse: an aspect of neoliberal discourse that refers to how individuals deem everything that happens in their lives to be their responsibility and where asking for help, or even acknowledging the need for it, is seen as a sign of weakness and therefore unacceptable (Peacock, Bissell, and Owen 2014). In these participants' accounts, individuals have no excuses for (continuing to suffer from) poor health and are entirely responsible for not »taking advantage« of the New Zealand state's health services. Ros, who worked in the health care sector, admonished that, »it is your responsibility to go and check [your] medical health. You have to. It is your responsibility to go see your general practitioner […] at least yearly. Because everything here's provided.« It was typical for participants to label themselves (and others) lazy and undisciplined for failing to follow their prescriptions, comply with doctor's orders, and commit to healthy habits.

Even when participants point out the inadequacy of the state's health services, the emphasis is on being provided limited choices and being *able to choose better* through insurance:

> Interviewer: The health insurance, if I understand it correctly, it's like there's, the health services here [in New Zealand] are free. So what is the purpose of getting that?
>
> Fey: Basically, health insurance is so that you don't need to wait. See, the public health system is free, okay, whatever your illness is it's good. But if it's not life-threatening you will go into a list. [provides specific examples] You don't need to use your health

> insurance unless for example you go to the hospital. You were hospitalized because, say, you have an ulcer that you need to get operated. And you want a higher quality, you don't want [public hospital], you want [private hospital]. Then you say to your doctor, ah, »Could you move me to [private hospital], please?« That's when your health insurance comes in. You have choices when you have health insurance.

In Fey's account, the individual (»you«) is positioned as suffering from illness and from less-than-ideal public health services, as wanting or needing particular services, as actively seeking these through doctors, and as having choices with private insurance. This supports the earlier argument that prevailing understandings of health care provision draw more on a discourse of individual responsibility and consumption rather than on a rights and welfare discourse as might seem at first glance, e.g., previous accounts where Vangie described the New Zealand government as »looking after« its older citizens. Participants' understandings of health surveillance as a (New Zealand) state-provided benefit they should take advantage of, and the meanings around privately purchased insurance as expanding the conscientious health consumer's options, are made in the context of neoliberally guided health policies and practices that maintain reduced state support for social services and construct the aging body as a site of vulnerability, risk, and self-vigilance.

Critics have commented that new forms of medicine that emphasize surveillance (under the guise of prevention) reconfigure new relationships between the state and its citizens (Higgs 1997; Armstrong 1995). In particular, the ability of states to scrutinize individuals and compare them against an idealized norm allows the state to assign individuals to particular (»target,« »vulnerable,« or »at-risk«) groups, without necessarily taking responsibility for their care (Higgs 1997). What this accomplishes, according to Higgs, is the separation of those individuals who are responsible, self-supporting, and self-reliant from those who are not. A »consumer citizenship« (Higgs 1997) is encouraged—one where individuals are asked to make rational, informed choices about their health. In New Zealand, this is evident in participants' acknowledgement of the state's support

for annual health checks and public health services alongside the long waits and expensive appointments with specialists. It has led a good number of participants[7] to »exercise their right to choose« and obtain health insurance.

Conclusion: Health in aging as an embodiment of migrant success

Taken together, the claims participants made about the achievability of healthy aging in New Zealand accomplish two things for aging Filipina migrants. First, they propose that healthy aging is a norm in New Zealand, easily achievable by its (responsible) citizens. Second, they construct migration as a successful strategy for improving one's life and aging. For aging Filipino migrants, the meanings of health extend beyond having a functional body for everyday life, beyond an obligation to the public, and into evidence of success at migration, or what Foucault calls the »enterprise of oneself« (2008, 320).

The extension of such meanings is made possible by the strong resonance between discourses of individual responsibility and self-sufficiency in health and aging and discourses surrounding Filipino migration. Migration scholars point out how such discourses obscure the impact of global inequalities, gender inequalities, and the reduction of social support and protection mechanisms provided by the state, leaving individuals to become entrepreneurial, self-sufficient, and responsible (McLaren and Dyck 2004; Guevarra 2009; Rodriguez 2002; Inouye 2012). Just as white, middle-class Americans see individual responsibility for health as having strongly positive meanings (Crawford 2006), Filipino migrants who are sold a particular version of empowerment (Guevarra 2009) may find the rhetoric of personal responsibility in health both appealing and logical for echoing the politically constructed imperative to do what one can for oneself, family, and country.

As some critics of neoliberally guided discourses around health argue, the construction of health as an individual responsibility and of biomedicine as producing a »cornucopia of choices« (Briggs and Hallin 2007, 53) for

7 Seven participants volunteered that they purchased health insurance.

the »patient-consumer« excludes »(t)hose who are not middle class, […] or who do not experience neoliberal society as a ›rich range of choice‹« (Briggs and Hallin 2007, 54). Such a construction renders invisible more than ten percent of older persons 65 to 84 years of age in New Zealand who cannot say they are in good or excellent health (Pool et al. 2009),[8] and the 6.3% (or over 1 in 20) of older persons who needed to see a general practitioner but did not, mainly because they could not afford it (Ministry of Social Development 2007).[9] The construction of health as an individual responsibility renders invisible the challenges that aging migrant Filipina face—greater stresses in the workplace, the double burden of care work and employment, and smaller or no savings for retirement (because of the shorter length of employment in the host country or because of the need to send remittances). Participants' constructions of health and aging, while encouraging individual empowerment, choice, and autonomy, simultaneously deny the many other factors beyond individual control that contribute to health, and regard information about health inequalities[10] as evidence of particular groups of people (e.g., Māori, poor people) not taking enough responsibility for their health (Peacock, Bissell, and Owen 2014) rather than of social conditions producing the inequalities that become *embodied*.

8 Data based on the Enhancing Wellbeing in an Ageing Society (EWAS) survey in 2007. Note that this survey excluded those 85 and above, and those who were institutionalized, which could mean that the actual proportion of those who perceive themselves to be in poor health may be higher.

9 Data based on the New Zealand Health Survey 2003.

10 For example, the death rates for Māori, which are (at least) twice as high compared to non-Māori at the ages between 65 and 74 and the negative correlation between economic deprivation and life expectancy (Ministry of Social Development 2007).

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