Understanding Policy Influences on Health and Occupation Through the Use of the Life Course Health Development (LCHD) Framework

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Life course health development (LCHD) is a framework that considers the transactional nature of risks and protective factors along the life trajectory and how this context influences health. Public policies, from health care to education to social services to labor laws, have many goals, including lessening and eliminating health disparities, yet inequities in health services and outcomes remain. Policy is a contextual factor that may be overlooked when examining influences on health and occupation. As such, the LCHD framework may assist occupational therapy practitioners in understanding the influences of policy—both successes and failures—on occupation. In this article, we introduce the principles of LCHD and use this framework to illustrate analysis of a policy example of paid family leave, demonstrating how gaps in or unintended consequences of policy may contribute to disparities in health and occupation for certain populations.

It is well established that the United States lags behind other nations in the health of its population despite continuing to spend more on health care than peer nations (Galea & Vaughan, 2018; National Research Council & Institute of Medicine, 2013), even with significant efforts at the federal and other levels of policy. *Policy* is a course of action undertaken to address questions and guide future planning (McLaughlin & McLaughlin, 2019), and it may be a determinant of health or other social experiences. *Social determinants of health* "are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (U.S. Department of Health and Human Services [HHS], 2019, para. 5); they help to explain why disparities continue to persist. To address social determinants of health, public health scholars have identified the need to "think and do differently" (Galea & Vaughan, 2018, p. 26) in research and policy actions.

As these new and different approaches to achieving societal health are proposed and undertaken, opportunities are created for occupational therapy in population health and health care policy. Given the rapidly changing landscape of policy in the United States, it is imperative to think critically about the influences of policy on occupation (Braveman, 2016; Mroz et al., 2015; Pitonyak et al., 2015; Rudman, 2013; Wicks & Jamieson, 2014). Life course health development (LCHD) is a framework being applied in public health and related disciplines to the analysis of complex influences on health, such as policy, and to inform research, program development, and policy reform (Halfon & Forrest, 2018; Halfon & Hochstein, 2002; Halfon et al., 2014). Therefore, the LCHD framework may be instructive when considering social determinants such as policy that go beyond the immediate therapy environment (Mroz et al., 2015; Pitonyak et al., 2015). In this article, we argue that LCHD can also be used to examine policy influences on occupation (Gupta et al., in press; Pitonyak et al., 2015, 2016), particularly when policy intersects with other complex factors, including physical and social aspects and cultural expectations—that is, those factors that are part of everyday living (Rudman, 2013).

This article evolved from multiple conversations about our individual research, program development, and policy analysis work focused on situations of occupational injustice and the concept of occupation as a social determinant of

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health (Gupta et al., 2016, in press; Pergolotti et al., 2015, 2017, 2018; Pitonyak et al., 2015, 2016). One result was a collaborative panel illustrating instances of racial disparities in occupation related to gaps in or the unintended consequences of policy, "Broadening the Occupational Science Lens: Racial Considerations in the Landscape of Shifting U.S. Demographics," presented at the 2016 Society for the Study of Occupation:USA (SSO:USA) Annual Research Conference (Dunbar et al., 2016). Paralleling this effort, the first and third authors collaborated with the Life Course Research Network at the University of California, Los Angeles, to present a forum, "The Importance of Occupation in Life Course Health Development: Shifting the Paradigm in Theory, Research, and Practice," with Dr. Neal Halfon at the 2017 SSO:USA Annual Research Conference (Pitonyak et al., 2017).

Our aims in this article are to (1) introduce the general principles of LCHD, (2) illustrate how the use of a framework such as LCHD informs analysis of policy influences on health and occupation, and (3) increase understanding of the linkages among health and policy, occupational injustices, and population health outcomes. Such analysis may inform occupational solutions that can be integrated into policy development and reform (Wicks & Jamieson, 2014).

Principles of Life Course Health Development

"Lifecourse-informed models of health introduce a new way of thinking about how health and disease develop across the life span, fundamentally challenging existing simple biomedical, and more recent multiple risk factor[,] models" (Russ et al., 2014, p. 498). Life course theory emerged from the epidemiologic study of health disparities and social determinants of health. A life course perspective links life adversity, particularly risks early in life, with long-term effects on health, such as adult chronic disease (Hertzman, 1994; Kuh & Hardy, 2002; Marmot et al., 1978), and it is based on the premise that complex biological and social factors affect health development in different ways, and with varied impacts, at critical periods of development.

Halfon and Forrest (2018) explained that "health development integrates the concepts of health and developmental processes into a unified whole" (p. 26). As a dynamic, emergent process, health development is the outcome of transactions among people's internal bodily systems and external environments and diverse contexts: genetic, physical, social, family, psychological, health care systems, and culture or policy (Halfon & Forrest, 2018; Halfon & Hochstein, 2002; Halfon et al., 2014). Halfon and Forrest also proposed principles of LCHD that seek to further explain the complex, adaptive process of health development. We provide descriptions of these principles in Table 1 and build on previous examples (Kim et al., 2018; Larson et al., 2018) of the application of these principles to disparities in health by demonstrating how they guide analysis of policy influences on occupation. We believe that understanding the LCHD principles as they relate to occupation will open new doors for occupational therapy practitioners, scientists, and scholars to consider policy when analyzing participation and performance. The example we describe next illustrates how policy may not address all gaps in accessing healthy occupations and thus contributes to disparities in health development.

Lack of Paid Family Medical Leave: Influences on Occupation and Health

Family leave from work, especially if paid, is an essential benefit for parents who want to establish a positive early relationship with their infant and foster the best start for LCHD (Zero to Three, 2018). This benefit allows parents to take time off work for situations that include the birth or adoption of a child for bonding as well as for responsibilities such as taking an infant to well-baby visits. Family leave also provides an extended opportunity to establish breastfeeding and is associated with improved maternal health outcomes (Chuang et al., 2010; Jacknowitz, 2008; Jou et al., 2018; Mandal et al., 2010; McCarter-Spaulding & Horowitz, 2007; Skafida, 2012). However, the United States is one of three countries worldwide that has not implemented a national paid family leave policy; Papua New Guinea and Suriname are the other two (WORLD Policy Analysis Center, 2019).

Table 1. Principles of the Life Course Health Development Framework

Principle	Brief Description
1. Health development	Health development integrates the concepts of health and developmental processes into a unified whole.
2. Unfolding	Health development unfolds continuously over the lifespan, from conception to death, and is shaped by prior experiences and environmental interactions.
3. Complexity	Health development results from adaptive, multilevel, and reciprocal interactions between people and their physical, natural, and social environments.
4. Timing	Health development is sensitive to the timing and social structuring of environmental exposures and experiences.
5. Plasticity	Health development phenotypes are systematically malleable and are enabled and constrained by evolution to enhance adaptability to diverse environments.
6. Thriving	Optimal health development promotes survival, enhances well-being, and protects against disease.
7. Harmony	Health development results from the balanced interactions of molecular, physiological, behavioral, cultural, and evolutionary processes.

Note. From "The Emerging Theoretical Framework of Life Course Health Development," by N. Halfon and C. B. Forrest, in *Handbook of Life Course Health Development* (p. 21), by N. Halfon, C. B. Forrest, R. M. Lerner, & E. M Faustman (Eds.), 2018, New York: Springer. Copyright © 2018 by the authors. Adapted with permission of the authors from the original under the terms of the Creative Commons Attribution 4.0 International License (http://creativecommons.org/licenses/by/4.0/).

In the United States, unpaid family leave is currently available through the Family and Medical Leave Act of 1993 (FMLA; Pub. L. 103-3) for certain employees of companies with 50 or more employees (U.S. Department of Labor, n.d.). FMLA provides 12 weeks of unpaid, job-protected leave each year for qualified medical or family reasons, including caring for newborn or other children. The law allows states and employers to establish family leave policies that are more expansive than the FMLA; however, only a few states have done so (Domonoske, 2016; Zero to Three, 2018). Moreover, the majority of working parents are not covered under the existing FMLA because of the size of their employers, and many parents who would return to paid work after the birth of a child are not financially able to take unpaid leave, even if it is available (Zero to Three, 2018).

The LCHD principles of timing, plasticity, and thriving are particularly applicable to understanding how this policy situation negatively affects individual and family occupations and health and subsequently contributes to occupational injustices and health disparities. Using these principles we aim to illustrate how application of a framework such as LCHD helps inform analysis of policy influences on occupation:

- *Timing:* The perinatal period is a time-sensitive period (Halfon & Forrest, 2018) not only for attachment but also for LCHD and the prevention of chronic disease among both infants and women (Jou et al., 2018; Pitonyak et al., 2016).
- *Plasticity:* Research continues to elucidate the important relationship among stable, loving, early relationships; their implications for brain development (Halfon & Forrest, 2018); and later mental health. At the same time, recommendations for breastfeeding are based on extensive evidence of its life course health benefits (HHS, 2011). Given this evidence, policy that enables parents to perform early family occupations essential for bonding and attachment helps to foster health development and actualization of occupational routines and roles.
- *Thriving:* Early family social participation fosters attachment and the foundations of mental health, illustrative of the principle of thriving, which posits that optimal health development promotes well-being and disease prevention (Halfon & Forrest, 2018).

Bringing these principles together, we theorize that health development enables certain outcomes such as quality of life, wellness, and well-being and that occupational engagement is a key mediator, or determinant, of health (Pitonyak et al., 2015). Therefore, the lack of optimal paid family leave—a policy gap—is a contextual factor that inhibits access to desired family occupations, such as bonding (social participation) and breastfeeding (feeding, eating, and child rearing) that are critical for development and well-being. Through optimal paid family medical leave, the United States could align protective or health-promoting policy with this sensitive period of health development.

Increasing Understanding of Policy Influences on Occupation

Policy, whether intended to foster health, education, or other social outcomes, often has broad influences and consequences once implemented. These consequences affect diverse social groups in ways that may contribute to disparities in health and participation rather than diminishing them (Gerlach, 2015; Rudman, 2013). Gerlach (2015) proposed that "socially responsive and equity-oriented occupational therapy theorizing and practices must be responsive to the multilayered, contextual, and structural nature of people's lived experiences of intersecting forms of marginalization and their agency and resistance" (p. 251). A fundamental belief of occupational therapy is that health is determined by the quality of everyday living and the ability to participate in occupations that give meaning and purpose and are required to fulfill societal roles and foster personal ones. As such, the LCHD framework may be a useful tool for occupational therapy practitioners and scholars to use in deeper analysis of how policy can limit access to desired occupations, and thus to health, and move occupational therapy toward Gerlach's call for social responsiveness and equity-oriented practice.

Although occupational therapy practitioners consider contextual influences on occupation, the impact of policy is not a traditional component of thinking during the occupational therapy process (Mroz et al., 2015; Pitonyak et al., 2015). It is timely for the field of occupational therapy to broaden its understanding of policy as both a social determinant and a contextual factor. Occupational therapy considers the person in context, and context includes policy and its impact on occupation. Health is an asset and a resource for life; occupations are a means to health and well-being (Gupta & Taff, 2015). Fostering a deeper understanding of policy influences on access and opportunities to engage in occupation among practitioners in the United States is one way to move toward socially responsive and equity-oriented occupational therapy.

Occupational therapy scholars have discussed how thinking about social determinants of occupation, such as policy, needs to be included in the occupational therapy process—particularly to actualize client-centered care (Bailliard, 2013; Gupta & Taff, 2015; Hocking, 2017; Mroz et al., 2015; Pitonyak et al., 2015; Rudman, 2013; Townsend & Wilcock, 2004; Whalley Hammell & Iwama, 2012). With occupational therapy practitioners' understanding of habits, routines, and participation, they can bring a deeper understanding of the lived experience of policy; therefore, practitioners have a role and unique perspective to help policymakers understand the impacts of policy, or its gaps. Moreover, they have the role of constructing occupational therapy interventions or programs to address habits, routines, and participation to enable people to overcome negative impacts of policy.

Although occupational therapy practice in the United States requires engagement with policy, this engagement primarily pertains to service delivery, reimbursement, and scope of practice. In this article, we have made a case for the profession's consideration of context to go beyond a view of individual factors and to understand that clients' everyday living conditions are affected by multiple systems, including policy. Issues of social determinants and systems that address these determinants will benefit from the inclusion of an occupational perspective and its contribution to creating conditions that develop productive and well-adjusted citizens.

Whalley Hammell and Iwama (2012) stated, "If occupational therapists are to take seriously their espoused commitment to enabling access to participation in occupation, the inequitable conditions of people's lives will need to be addressed" (p. 385). People have the right to engage in meaningful occupation that contributes to well-being (Whalley Hammell & Iwama, 2012). Durocher et al. (2014) argued that access to meaningful occupation is a human right. Last, Townsend and Wilcock (2004) decreed that full participation in society requires means. Policy, or its gaps—such as failure to expand access to paid family medical leave—contribute to health inequities by limiting possibilities for participation in daily life. The conditions of everyday living encompass broader social determinants of health. Tackling health disparities and meeting the societal needs of the day warrant that practitioners "walk their talk" by enhancing their understanding of contexts at multiple levels as defined by the LCHD framework and bringing their unique understanding of occupation as a social determinant to the changing approach to health.

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