



Legislative and  
Policy Update

# Pediatric Health Policy Analysis: The Emergency Medical Services for Children (EMSC) Act and *The Wakefield Act*, Utilizing Social Construction of Target Populations

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Every year, there are 31 million children who visit the emergency departments of our nation's hospitals. A majority of these pediatric emergency department visits are made by children under the age of 3 years. Although, much is made of the freestanding children's hospitals that are dedicated and staffed to care for the special needs of the child, in reality, 90% of children who require emergency care are seen in general hospitals. It is not unusual for 30% of a general hospital's emergency department patients to be children (Gausche-Hill, Johnson, Warden, & Brennan, 2003; McCaig & Burt, 2005). But are these facilities adequately prepared to render emergency care to children? Does a sick or injured child receive the same level of care as that of an adult?

## Background

In 1985, the U.S. Congress authorized the first federally funded program that focused specifically on improving the pediatric component of emergency medical service care. This act stimulated the organization of EMSC, the emergency medical services for children. Nearly a decade after the state, regional and national initiatives were jump started, the Institute of Medicine (IOM) still noted a great disparity in the emergency services offered to adults and children (Institute of Medicine, 1993). Concurrently, there was a proliferation of guidelines to support the preparedness of pre-hospital and emergency department personnel. Pre-hospital curriculum and equipment lists were established, recommendations were made and the states developed various methods to address the complexity of providing for sick and injured children (ACEP, 1998; Seidel et al., 1996). A study published in 2001 by the Consumer Product Safety Commission, on behalf of the Health Resource and Services Administration's (HRSA) Maternal Child Health Bureau's Emergency Medical Services for Children Program (EMSC), concluded that emergent and critical care of children was poorly integrated and regionalized. In April of 2001, *The Annals of Emergency Medicine* published *Care of the Children in the Emergency Department: Guidelines for Preparedness*, which was jointly developed by the American College of Emergency Physicians (ACEP) and the American Academy of Pediatrics (AAP) (ACEP, 2001).

Soon after these guidelines were published, America was attacked and terrorism brought to light deficits in our connections between public health and health care delivery. The nation was consumed with the topic of emergency readiness, yet the pediatric guidelines that were so timely seemed as if they were ignored due to the focus on nation-

al preparedness. Over the past 4 years, there has been a heightened interest in emergency preparedness and emergency services coordination. Yet, there has been little concern with pediatric emergency readiness. The interest and financial support has gone to predominately support communications and coordination of local, state, and federal emergency resources. The money and the political focus have been on the general population, on adult care.

Children are not just small adults. Repeatedly in the readiness funding, in the research and in the emergency drills, children have largely been ignored. There is not a national strategy to address the complex emergency care needs of children. In light of the current events that center on national readiness, a potential influenza outbreak, risk of disaster, and threat of bioterrorism, children's readiness must also be acknowledged and funded. Yet, in the 2006 budget, there was no funding to support reauthorization of the EMSC. The proposed budget eliminates funding for the EMSC program for the first time in 20 years. The House passed Labor-HHS bill included an allocation of \$19 million, while the Senate Appropriations Committee provided \$20 million, the 2005 appropriation level.

Many public health programs have been well funded at the initiative of the executive branch. Monies have been available at unprecedented levels for the Department of Homeland Security and the Federal Emergency Management Agency (FEMA) for the last 3 years in order to pursue the improvement of public health and emergency services. The United States government has spent over \$1 billion a year to address the public health needs in efforts to provide for national disaster and emergency readiness, yet the simplest emergency needs of children are still not being met (Hearne, Segal, Earls, & Unruh, 2004). There is little acknowledgement of this incongruence, and there appears to be little voice for support of emergency care for children.

## Policy Objectives

In response to the FY 2006 zero funding and lack of reauthorization for EMSC, Senator Inouye (D-Hawaii) has introduced legislation to reauthorize the EMSC program for the next 5 years. Senate bill S.760, the Wakefield Act, would allow the EMSC program to carry out its existing initiatives and continue to address gaps in care. The purpose of this act is to reduce child and youth morbidity and mortality by supporting improvements in the quality of medical care children receive. The Wakefield Act would allow the EMSC to continue in its mission to improve the pediatric components of emergency medical care, instead of the current executive proposal that would place EMSC under the trauma reauthorization bill.

It is ironic that the year EMSC is celebrating its 20<sup>th</sup> anniversary; it should be threatened with not being reau-

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thorized and zero funding. During the past few years there has been a growing focus on national emergency preparedness and emergency readiness. In September 2001, the United States suffered the terrorist bombing attacks on New York and Washington DC, and followed soon thereafter by the anthrax (biological agent) terrorist attacks in the Northeast. These attacks heightened the nation's awareness of the vulnerabilities in the health care system. The public and private health care delivery systems were not able to adequately address the needs of the nation. Emergency care services and public health departments received much deserved attention and funding at the state and federal levels.

Children represent 25% of the population, and that number translates to over 73 million "kids" with very different emergency care needs. The lack of knowledge and experience in the emergency care of children has been discussed and researched for over the past three decades. The causes and concerns are numerous, such as the delivery of care systems, pediatric specialization, regionalization, and need for different and multiple sizes of equipment. The deficit is compounded by the fact that much of the knowledge regarding disaster medical management and care of mass casualties comes from the military experience (Gorelick, 2003; Moody-Williams, Linzer, Stern, Wilkinson, & Athey, 1999; PECARN, 2003; Seidel & Henderson, 1991; Seidel & Gausche-Hill, 2001; Surpure, 1991).

Many believe that a bioterrorism event would be suffered more acutely in the pediatric population due to a host of factors. Children are vulnerable to a terrorist attack or an emerging infectious disease. Their developing bodies place them at a greater risk for many of the difficulties associated with a terrorist event. Children are particularly susceptible to aerosolized agents as they breathe more times per minute than adults and therefore they would be exposed to a relatively larger dose of toxin. Children are also more susceptible to noxious agents that act through the skin as they have a greater body surface area than adults. If the agent or disease process causes vomiting and/or diarrhea, children are less able to maintain a fluid balance, making them more prone to serious dehydration. They are also more prone to death from loss of blood or body fluids as they have a smaller circulating blood volume than adults. These physiological differences are significant, but perhaps of even greater importance are the cognitive and gross motor vulnerabilities that would prevent the timely escape. There are very few articles in the literature that address these specific pediatric readiness concerns (Bernardo, 2001; Ferguson, 2002; Halfon, Inkelas, DuPlessis, & Newacheck, 1999; Harbison & Novak, 2002; Rosenfield & Bernardo, 2001).

Interestingly, it has been recently noted that preschoolers present at an emergency department approximately 5 weeks before the "spike" of an outbreak of influenza presents in the adult population. Data compiled at the Children's Hospital Informatics Program at the Harvard-MIT Division suggests that healthy preschoolers drive flu epidemics. Moreover, flu illness in children under the age of 5 was the strongest predictive indicator of pneumonia and influenza deaths as determined by the CDC database. A similar phenomenon was noted in Japan, when infectious disease tracking was done to assess whether an infectious disease was more likely to be spread by children or the elderly. The goal was to assess if there was a limited number of vaccine available, which population group should receive the vaccine for the "most common good." It was discovered that the children were much more likely to spread the infection and thus children should be vac-

inated first in order to attempt to control the disease (Brownstein, Kleinman, & Mandl, 2005). Therefore, whether the child is ill from an injury or an illness, from an outbreak of influenza, or a terrorist's attack, all emergency departments that care for and serve children then are obligated to have the necessary essential pediatric resuscitative equipment.

As the nation plans for a large-scale event, there are numerous studies that reveal a still lacking basic emergency department readiness for critically ill or injured children (Athey, Deal, Ball, & Weibe, 2001; Seidel & Gausche-Hill, 2001). As recently as 2003, the CDC surveyed the scope of the pediatric emergency supplies, at the request of the Health Resources and Services Administration, and the Emergency Pediatric Supplies and Equipment Supplement (EPSES) revealed that only 11% of emergency departments answered "yes" to all of the essential items on their supply list that was in the 2001 (ACEP and AAP) guidelines, and this was no different than a National Emergency Institute Supply Survey (NEISS) that was done in 1998 (Middleton, 2005). These national surveys, and the fact that the emergency departments have not changed in their adequacy of pediatric supplies, highlight the powerlessness of this vulnerable population.

The presence of basic equipment for pediatric resuscitation should be a *standard* in the hospital emergency departments. In 1993, the IOM report stated that agencies with jurisdiction over hospitals should require that "hospital emergency departments have available pediatric equipment and supplies appropriate for the emergency care of children" (Institute of Medicine, 1993). Why are we still two decades later not adequately prepared and supplied to care for our injured or ill children?

### Political Public Policy Analysis

To explore the politics of children's emergency medical services policymaking, this analysis uses Schneider's and Ingram's Theory (1993) of Social Construction of Target Populations. The forward of Schneider's and Ingram's book (2005) on social construction and public policy begins with the following statement, "If social scientists ever discover the molecule of governance, surely it will be the category" (Schneider & Ingram, 2005). It is the social construction of categories, of target populations, that are the building stones (and votes) of a democratic government. The social construction theorists focus on the construction of these target groups in the realm of public policy. Using this theory begins to attempt explaining the phenomena of how and why children's health needs are neglected in our nation's health policy.

Children's health needs have often been neglected. There is a long history of children's health care needs being either ignored or under-funded. How can a nation that sincerely believes that it is "child friendly" and highly values the "life of a child" provide less than optimal emergency pediatric health care? This analysis explores the Wakefield Act, S.760, in the terms of social category, entitlements, and deservedness. The appropriations of the Wakefield Act would be targeted to address the pre-hospital and emergency care needs of children. For example, what if the next disaster or disease outbreak, whether natural or man-made, occurs in an area that has a specific pediatric target? In this era of "all hazards readiness preparation," the federal agencies are neglecting a special population and the emergency and critical care needs of children are being ignored. This legislation would allow for continuation of assessment, survey, and education in the area of pediatric emergency care.

## Social Construction of Pediatric Emergency Care

**Pediatric care.** Children's emergency and critical care health care services are poorly standardized and poorly integrated within the health care system in the United States. Public policies and programs for children are often fragmented and are added as a second thought to an adult focused health care policy (Institute of Medicine, 1993). There are only approximately 320 children's hospitals in the nation, mostly based in urban areas and associated with teaching facilities. Yet, less than 10 % of pediatric emergency visits occur at these designated children's hospitals. Some states have "regionalized" pediatric emergency care. Yet, the EMS system must be prepared to care for all ill or injured children. Pediatrics must be included in all aspects of emergency care readiness so that they may be cared for in the same sophisticated emergency care system as adults. Currently, emergency departments across the nation are suffering greatly due to facility closures and an increase in patient visits. Emergency departments are suffering a staffing and a financial crisis. Waiting times are increasing and more of the uninsured are seeking the emergency department for health care. The percent of children who visited an emergency department in 1999 was 17.9%, and in the year 2002 it was up to 22.4% (McCaig & Burt, 2005), yet hospitals are more likely to be missing essential resuscitative equipment and supplies and lack the coordination of services required to provide care to critically ill children (Institute of Medicine, 1993; Seidel & Gausche-Hill, 2001).

The number of children living in poverty has risen to nearly 20% of the population. Many of these children have sporadic health insurance coverage depending on their parent's employment status. Currently more than 9 million children having no health insurance (Hearne et al., 2004). There have been programs and policies that demonstrate and substantiate the theory of Schneider and Ingram in regard to the poor and powerless in the areas of race, age, immigration, and AIDS, but there has not been an analysis of the social construction theory with the target group of children (A.L. Schneider & Ingram, 2005; Schroedel & Jordan, 1998). The social construction of deservedness and entitlement has powerful consequences for analyzing health policy for children.

Historically, children have often been the focus of "undeserving/unentitled" target constructions. Child labor laws, child neglect/abuse, and custody laws may be a few categories to describe society's interpretation and ultimate acceptance of these laws. Many times in the courtrooms, children are viewed as possessions, as property of the parents and thus not deserving of individual value. Policy and the courts make agent of this construct (A. Schneider & Ingram, 1993). There is a dearth of research in pediatric emergency care. The existence of social construct theory in children's health inequalities has not previously been addressed.

Public policies are significant in constructing group identities as they establish the boundaries and define the target social construction that may cross national borders. Politics of identification with a target population is persuasive in analyzing and making public policy. Using the theory of social construction, it is easy to see that policies are meant to determine *how* target groups are constructed. Politicians and policymakers are the agents of social construction. They shape the boundaries of the target population, determining the parameters of discussion regarding group identity. Public policies often constrain the way that citizens think about groups other than their own. Within the early AIDS policymaking, the target group of gay men was treated differently once other "faces" were identified. The

**Table 1. Analysis of Factors Related to Policy**

**Social Factors:** Children are often approached cautiously in legislation as there is a great respect for the role and responsibilities of "parent" in the culture. Children are non-voters and most families do not envision their use of pediatric emergency facilities, therefore there is not a large electoral pay-off for such legislation.

**Economic Factors:** The funding for this project is small and inconsequential in the overall budget. The concern is that if the EMSC were to be placed under the Trauma Authorization, the funding appropriated would focus on general emergency care and the clinical focus would once again shift away from pediatric emergency care.

**Ethical factors:** The key principles in conflict here are justice and fairness. Children are consumers of emergency care and hospitals advertise to their market share. Also, the *Utilitarian* concept of "the greatest good for the greatest number" comes into play when assessing the rationing of vaccine or limited treatments. It is interesting to note that this bill has 15 senatorial co-sponsors and four (approximately 25%) of those are women, an intriguing statistic since only 14% of the U.S. Senators are female in the 109<sup>th</sup> Congress. Are women more apt to accept the role of mother/child as "valued"? Are they more willing to see the benefits of children's health as beneficial to families? Is the construct different for the sexes?

**Political and Legal Factors:** In this time of scarce resources, the funding of emergency care may raise concerns of over-allocation due to the relatively small numbers of pediatric resuscitations. Yet the societal costs in morbidity and long-term care of these children would impact those equations. The rationing of health care resources is not a subject that this country has yet to begin to discuss. Caring for the young and vulnerable population carries with it a moral and responsible foundation for the continuation of society and an economic base. Yet, the political reality is that unless this legislation receives strong Republican support in this extremely partisan 109<sup>th</sup> Congress, it will simply die in committee.

**Stakeholders:** This bill does not have a strong republican co-sponsor, therefore it may simply die in committee as the majority of bills do. There is not a strong voice for children's health, and health care issues are just recently coming to the political surface. It would be difficult for an elected official to be against the equity of emergency care services of children. Yet, in times of financial constraints, social programs with little electoral pay-off may go unfunded.

new construction to the group, such as the child with hemophilia named Ryan White, changed policymaking.

## Target Populations

Constructions in policy rely heavily on context. Therefore, the historical, economic, political, and legal contexts are all important facets to consider in the analysis (see Table 1). As they are authorized by a representative body, they are somewhat symbolic of and approved by public opinion. Children have been viewed as "property" of their parents, without legal rights right's and without legal access.

Law has been very hesitant to interfere in the “privacy” of the family. The history of our democracy is one of citizenship, yet this citizenship is for adults. Long ago, competent, white, land-owning males were the only citizens. This construct has slowly evolved over the centuries to include women and those “citizens of color and poverty,” but the age of emancipation has not changed. Children are most often “constructed” in the social class of their families. As an example, the child’s *right* to an education is pervasive but the quality of education is still most often directly linked with the parent’s social construct.

The welfare policy of the United States is a tiered system, with a superior tier for those “deserving” groups such as the handicapped and elderly, who have worked and proved themselves worthy. The inferior tier of the welfare system is associated with disadvantaged groups, such as poor women and children of color (A.L. Schneider & Ingram, 2005). One could argue that the welfare system is viewed very differently relative to these two groups:

- The Social Security Disability Insurance policy, by program design, supports the needs of an entitled and deserving group of individuals that have worked and contributed to society. These individuals also have an active collective bargaining organization and are not hesitant to act since they infer that the government has a positive image and construct of their identity.
- The Aid to Families with Dependent Children policy, by program design, builds on the status of inferiority and helplessness. It affects the constituents by their experiences of a burdensome system. These individuals soon realize the limits of their bargaining and of what a citizen can expect from government.

The policy design of these two social welfare programs, one that has “empowered” the elderly and the other that has re-enforced the helpless role, has created two very different social constructs and thus two very different “citizenries”. The cues that these people pick up from the program design affect their functions as citizens and their ability to affect government.

## Politics and Social Construction

**Politics of children’s health.** Many children have thus been lost in the construct of unworthiness and failure to participate in the political process. The “battle” between the elderly and the young is an interesting observation of social construct and is present in many legislative developments. The social construct of the elderly has gained status due to the political strength of the collective body. Yet the strength of this organization should in no way negatively affect the decisions regarding the care of children. It is interesting to watch the “either/or” phenomena that occurs in much of the U.S. social and health legislation. Public policies are written by a legislative body, which is constructed by a majority of older white men, who in turn construct policy in terms of “their own values and their own struggle for status. Policy therefore is more reflective of the powerful male view of societal needs. Social construction of the target population identity is “created at the intersection of policy, media discourse and the courts” (Schneider & Ingram, DiAlto, 2005, p. 102).

**Social construction of target groups.** Social construction of target populations refers to the cultural or popular images of groups that are affected by public policy. Therefore, in analyzing the construct for emergency care of children as a target population, no one visualizes that “image” as part of their child’s destiny. This defined group of children have no pre-characterization, no membership

per se, except that of being the “child” who has less-than-optimal parenting, and is thus at greater risk for an accident or illness. Policy sends the message regarding what government is responsible for and which citizens are deserving of such actions. This explains why some groups are more deserving or advantaged, independently of politics.

Research on public policy formulation has promulgated two popular reasons that policymakers create policy: to get re-elected, and to address a widely acknowledged public concern. Social constructions are important to use in both of these considerations and in light of the analysis of the Wakefield Act. Social constructions become part of the reelection strategy when public officials acknowledge the reaction of the target population to the policy and also acknowledge the reaction of others to whether the target population *should be* the beneficiary of the policy. Thus, the power of the target population, constructed as votes, wealth, and collective action, will predict the approval or disapproval of a policy directed at a certain target population. As Schneider and Ingram (2005) present the target populations:

- *Advantaged* groups are seen as powerful and positively constructed, such as the elderly and veterans;
- *Contenders* are those groups that may be rich and powerful but negatively constructed, seen as undeserving, such as unions and the rich;
- *Deviants* are those populations that are seen as powerless and negatively constructed, such as criminals and gangs; and
- *Dependents* include mothers and children, which are generally considered politically weak, but usually carry a more positive construct. This political power model demonstrates the ease in presenting policy that will be well received by the strong and positively constructive group.

A great deal of political energy centers on the design of policy. This design will in terms of the specifications of target population, create a type of image that can be then used politically. There are outside forces such as scientists and businesses, who are part of the powerful and deserving construct, that may enter into the construct equation so it is not unexpected that pressure from professional organizations and the public produce effective public policies. Therefore, in the analysis of the Wakefield Act, even though the target population is seen as lacking power, the 32 professional health care organizations that have endorsed the Act create a larger power base for the elected officials.

## Benefits and Burdens

Analysis of the Wakefield Act would be incomplete unless an examination of the benefits and burdens were taken. Even when policy is seen to hold broad public interest objectives, it is commonly able to provide benefits to the powerful and positively constructed groups and burdens to the less powerful and more negatively constructed groups. This dynamic relationship between power and social construct presents the allocation of benefits and burdens to differently constructed target populations. Benefits are expected to be oversubscribed to the advantaged populations, whereas the dependents will receive too little beneficial policy and the burdens will become greater. This is demonstrated by the FY 2006 budget choice to place the EMSC concept under the Trauma Service arena, rather than the Department of Maternal Child Services at DHS.

In placing the EMSC under the Trauma Services Act, emergency service funding was to be grouped together. Thus, the benefits were appropriated to easily provide for

# The Wakefield Act

*“Where you stand on an issue probably depends on where you are sitting...”*

The need for adequate emergency care services for our nation's children has never been greater. The unique and special needs of the pediatric population during emergency and disaster management must be addressed. The “all-hazard” readiness of health care delivery today requires a different thinking than the more than 20 years ago when the Congress first recognized the need for and mandated the federal Emergency Medical Services for Children (EMSC). Since 1984, the EMSC has assisted in systematic health care delivery improvements for the emergency care of children in every state in the nation. But there was no celebration of this anniversary event as the President's Fiscal Year 2006 budget that was released a year ago requested NO funding for the EMSC program and thus in effect would eliminate the program (Krug & Kuppermann, 2005). Yet, as we start this New Year, there is an increase political interest in health care initiatives. There is a greater awareness now of our public health and health care system's vulnerabilities and yet the special needs of the most vulnerable members of our society are still being largely ignored. No one is in a better place to see, report, and evaluate on the unique and special needs of our nation's children than the nurses who care for them. This great responsibility falls on all pediatric nurses and health care providers to unify behind the cause of *Advocacy and Action* for all of the critically ill and injured children who need our care.

In February of 2005, the President's FY 2006 was released and there was no funding for the EMSC and the program's authorization was to expire at the end of the FY 2005. The program was to be bundled up into the trauma reauthorization program that too, was under-funded. Just a few days earlier, a horrible accident had occurred in North Dakota affecting one of nursing's health policy leaders. The accident had taken the lives of Mary Wakefield's brother and his two children, leaving Mary's sister-in-law and a 12-year old nephew with life-threatening and life-altering injuries. Mary Wakefield is enormously respected by many on Capitol Hill because of her role as champion for good health policy. This inspired six senators to do what they could to honor Mary and her family and acknowledge the need for good health policy. In response to the EMSC being zeroed from the FY 06 budget, Senators Daniel Inouye (D-Hawaii); Orrin Hatch (R-Utah); Edward Kennedy (D-Mass.); Christopher Dodd (D-Conn); Mike Dewine (R-Ohio); and Kent Conrad (D-N.D.) introduced the “Wakefield Act,” also known as S.760 the “Emergency Medical Services for Children Act of 2005.” This bill would authorize and fund the EMSC, which is the sole system responsible for the pre-hospital and hospital-based emergency care for children.

## Emergency Readiness – A Health Policy Concern for All Pediatric Nurses

It has been almost 5 years since the attack on the World Trade Centers and the Pentagon, and later the anthrax biological terror attack. Never again would health care be the same. Billions of health care-readiness dollars have been spent on making a more

continuous and coordinated health care system. Individual communities have since been affected by the Washington DC sniper, the infectious diseases of the West Nile virus, and Monkey Pox. The federal smallpox vaccine failure and the influenza vaccine debacle made the nation realize that the federal government and the public health system were not adequately prepared. Especially in light of potential influenza outbreak, and new emerging infectious diseases such as severe adult respiratory syndrome (SARS) and clostridium difficile, it is difficult to understand the gaps in pediatric emergency care standards.

Children are approximately 25% of our nation's population. Yet, their basic resuscitation equipment essential to pediatrics is still lacking. The recent attack by the twisted sisters; and Hurricanes Katrina, Rita, and Wilma, once again reinforced the need for coordination of public health and health care systems, and highlighted the fact that the needs of the poor and the vulnerable populations were not adequately addressed. The world is greatly concerned with the H5A1 pending global bird flu outbreak. Concerns with the H1A5 Avian flu demonstrate the particular vulnerabilities of children by the recent deaths of the young in Turkey. There is not a daily newspaper that doesn't address some readiness health issue...but have the special needs of children been incorporated into our nation's emergency readiness?

## Call to Action

The need for emergency readiness for children is urgent. Each pediatric nurse can play a role in calling attention to the need. Please contact the members of Congress who have introduced this bill and let them know you are grateful. Calling attention to this important piece of legislation lets your member of Congress know how caring for children makes a difference to you and how you vote. You can email directly by finding your Representative at [www.house.gov](http://www.house.gov) and Senators at [www.senate.gov](http://www.senate.gov). If they do not hear from those of us who understand the need, this bill is likely to sit in Committee and die. For a sample letter, visit the *Pediatric Nursing* Web site at [www.pediatricnursing.net](http://www.pediatricnursing.net).

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the powerful and the positively well-constructed target group. One can envision the potential for the need for trauma services – the classic scenario is the automobile accident and this is easily applied to the target population. It is more difficult for many to envision the need for pediatric emergency care. Pediatric trauma scenarios often carry the context of “accident” or lack of adequate parenting or supervision. The “typical” pediatric emergency department patient is a black, preschool male, who lives in the inner city, has Medicaid and receives his primary care in the emergency department (Burt & Overpeck, 2001; McCaig & Burt, 2004, 2005). This target population does not have the power or the positive influence to generate policy. But by placing the EMSC under Trauma funding, the policy pursuit is shaped to the entitled target population. As with many policies for dependent groups, such as children, politicians want to appear to be “kind.” Symbolic policies can assist political leaders in showing appropriate concern, yet they must also make the difficult allocation of scarce resources. It is also true that the trauma-related organizations hold a more entitled and deserving place of status than does the division of Maternal and Child Health. Yet, as in the past, when monies have been appropriated for emergency medical services, pediatrics has often been neglected and forgotten (Institute of Medicine, 1993).

### Policy Objective

The goal of the Wakefield Act is to authorize and fund EMSC and allow the EMSC to continue to ensure that children’s health care needs are given the attention and priority they deserve. The gaps in pediatric emergency care may be “invisible” as the overall system deficits in the EMS system are being identified. The authorization of the EMSC is currently threatened. Authorization is the legal authority to spend money for a program. If the authorization expires, funding may continue if allocated. But reauthorization places an importance on the program and promotes the opportunity for evaluation and review. Instead of placing children’s needs behind those of adults, it is necessary to explore the system of emergency care services as a unit and address all of the system needs in one plan.

Recent events, such as hurricanes Katrina, Rita and Wilma, show that vulnerable populations are neglected. These special populations often do not fit into the emergency management plan that was designed without their consideration. By dovetailing this EMSC legislation into the relationship with the DHS, perhaps some bridges could be established so the emergency and disaster needs of children could become an area of focus. It seems that in this time of impending pandemic flu, disaster readiness and bioterrorism threats, the emergency needs of children deserve a place at the political table. The Wakefield Act would provide the authorization and allocation of funds to ensure that children’s emergency needs be met today and facilitate the inclusion of children into the plans for national readiness tomorrow. As a nation, ethically, we must provide care to our children. And as a nation, economically, we need to take care of our greatest natural resource...our children’s health. Please write your Congressional representatives and tell them you support the Wakefield Act.

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