106TH CONGRESS  
1ST SESSION  

H. R. 3000

To establish a United States Health Service to provide high quality comprehensive health care for all Americans and to overcome the deficiencies in the present system of health care delivery.

IN THE HOUSE OF REPRESENTATIVES  

OCTOBER 1, 1999

Ms. Lee (for herself, Mrs. Christensen, and Mr. Jackson of Illinois) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Education and the Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

A BILL

To establish a United States Health Service to provide high quality comprehensive health care for all Americans and to overcome the deficiencies in the present system of health care delivery.

1 Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,
3

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

4 (a) Short Title.—This Act may be cited as the
5 “Josephine Butler United States Health Service Act”.


(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.
Sec. 3. Purposes.
Sec. 4. Definitions.

TITLE I—ESTABLISHMENT AND OPERATION OF THE UNITED STATES HEALTH SERVICE

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Sec. 101. Establishment of the Service.
Sec. 102. Appointment of Interim National Health Board.
Sec. 103. Powers and duties of the Interim National Health Board.
Sec. 104. Authorization.

Subtitle B—Organization of Area Health Boards

Sec. 111. Establishment of health care delivery regions.
Sec. 112. Appointment of interim regional health boards.
Sec. 113. Establishment of health care delivery districts and health care delivery communities.
Sec. 114. Election of community health boards.
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Sec. 118. Subsequent election and appointment of members of health boards.
Sec. 119. Modification of the boundaries of health care delivery areas.

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Sec. 121. Definitions.
Sec. 122. Membership of health boards.
Sec. 123. Meetings and records of health boards.
Sec. 124. Procedures for establishment of national guidelines and standards.
Sec. 125. Assistance to area health board members.
Sec. 126. Public accountability and financial disclosure by health board members.
Sec. 127. Inspector General for Health Services.

TITLE II—DELIVERY OF HEALTH CARE AND SUPPLEMENTAL SERVICES

Subtitle A—Patients’ Rights in Health Care Delivery

Sec. 201. Basic health rights.
Sec. 202. Right to paid leave to receive health care services.

Subtitle B—Eligibility for, Nature of, and Scope of Services Provided by the Service

Sec. 211. Eligibility for services.
Sec. 212. Entitlement to services.
Sec. 213. Provision of health care and supplemental services.
Subtitle C—Health Care Facilities and Delivery of Health Care Services

Sec. 221. Establishment of health care facilities and distribution of delivery of health care and other services.
Sec. 222. Operation and inspection of health care facilities.
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Sec. 301. Effect of State law.
Sec. 302. Qualifications of health workers.
Sec. 303. Establishment of job categories and certification standards.

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Sec. 311. Health team schools.
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Sec. 313. Payment for certain educational loans.

Subtitle C—Employment and Labor-Management Relations Within the Service

Sec. 321. Employment, transfer, promotion, and receipt of fees.
Sec. 322. Applicability of laws relating to Federal employees.
Sec. 323. Applicability of Federal labor-management relations laws.
Sec. 324. Defense of certain malpractice and negligence suits.

TITLE IV—OTHER FUNCTIONS OF HEALTH BOARDS

Subtitle A—Advocacy, Grievance Procedures, and Trusteeships

Sec. 401. Advocacy and legal services program.
Sec. 402. Grievance procedures and trusteeships.

Subtitle B—Occupational Safety and Health Programs

Sec. 411. Functions of the National Health Board.
Sec. 412. Community occupational safety and health activities.
Sec. 413. Regional occupational safety and health programs.
Sec. 414. Workplace health facilities.
Sec. 415. Employee rights relating to occupational safety and health.
Sec. 416. Definitions.

Subtitle C—Health and Health Care Delivery Research, Quality Assurance, and Health Equity

Sec. 421. Principles and guidelines for research.
Sec. 422. Establishment of institutes.

Subtitle D—Health Planning, Distribution of Drugs and Other Medical Supplies, and Miscellaneous Functions

Sec. 431. Health planning and budgeting.
Sec. 432. Distribution of drugs and other medical supplies.
Sec. 433. Miscellaneous functions of the National Health Board.

TITLE V—FINANCING OF THE SERVICE
Subtitle A—Health Service Taxes

Sec. 501. Individual and corporate income taxes.
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TITLE VI—MISCELLANEOUS PROVISIONS

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Sec. 602. Repeal of provisions.
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Sec. 604. Amendment to Budget and Accounting Act.
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1 SEC. 2. FINDINGS.

2 The Congress makes the following findings:

3 (1) The health of the Nation’s people is a foundation of their well-being.

4 (2) High quality health care is a right of all people.

5 (3) Many of the Nation’s people are unable fully to exercise this right because of the inability of
the present health care delivery system to make high
quality health care available to all individuals re-
gardless of race, sex, age, national origin, income,
marital status, sexual orientation, religion, political
belief, place of residence, employment status, or pre-
vious health status.

(4) The present health care system has failed to
provide financial coverage for health care services
for more than forty million Americans, and the per-
cent lacking such coverage grows each year.

(5) The present health care system has failed to
provide for sufficient effective preventive measures
that would address the deterioration in occupational,
environmental, and social conditions affecting the
health of the people of this Nation.

(6) Unnecessary and excessive profits and ad-
ministrative expenses have inflated the cost of health
care.

(7) The growth of for-profit medical care and
for-profit managed care is making it difficult for
health care personnel to provide, and users to re-
ceive, the full range of health services they believe to
be necessary, appropriate, and desirable.

(8) The health professions have failed to control
the cost of their services and the imbalance in the
number of health workers among geographic areas
or health care specialties.

(9) The present health care system has failed to
make full and efficient use of allied health workers.

(10) A United States Health Service is the best
means to implement the right to high quality health
care and to overcome the deficiencies in the present
health care delivery system.

SEC. 3. PURPOSES.

The purposes of this Act are:

(1) To create a United States Health Service to
provide without charge to all residents, regardless of
race, sex, age, national origin, income, marital sta-
status, sexual orientation, religion, political belief, place
of residence, employment status, or previous health
status, comprehensive health care services delivered
by salaried health workers and emphasizing the pro-
motion and maintenance of health as well as the
treatment of illness.

(2) To establish representative and democratic
governance of the Service through community boards
chosen through community elections, district and re-
gional boards selected by the community and district
boards, respectively, and a National Health Board
selected by the regional boards, subject to the ap-
approval of the President.

(3) To provide health workers in the Service
with fair and reasonable compensation, secure em-
ployment, opportunities for full and equal participa-
tion in the governance of health facilities, and oppor-
tunities for advancement without regard to race, sex,
age, national origin, sexual orientation, religion, or
political belief.

(4) To increase the availability and continuity
of health care by linking local health care facilities
to hospitals and specialized care facilities.

(5) To implement local, regional, and national
planning for the establishing, equipping, and staffing
of health care facilities needed to overcome present
shortages and redistribute health resources, espe-
cially for currently deprived inner-city and rural pop-
ulations, minority groups, prisoners, and occupa-
tional groups.

(6) To finance the Service through progressive
taxation of individuals and employer contributions,
and to distribute these revenues on a capitation
basis, supplemented by allocations to meet special
health care needs.
SEC. 4. DEFINITIONS.

For the purposes of this Act, unless the context implies otherwise:

(1) SERVICE.—The term “Service” means the United States Health Service established in section 101.

(2) NATIONAL HEALTH BOARD-RELATED TERMS.—

(A) NATIONAL HEALTH BOARD.—The term “National Health Board” means the National Health Board of the Service.

(B) INTERIM NATIONAL HEALTH BOARD.—The term “Interim National Health Board” means the Interim National Health Board, appointed under section 102, of the Service.

(C) APPROPRIATE NATIONAL HEALTH BOARD.—The term “appropriate National Health Board” means—

(i) the Interim National Health Board, prior to the initial meeting of the National Health Board under section 117, and

(ii) the National Health Board, at and after such meeting.

(3) HEALTH BOARD-RELATED TERMS.—
(A) **Health Board.**—The term “health board” means the Interim National Health Board, National Health Board, an interim regional health board, a regional health board, a district health board, or a community health board established under this Act.

(B) **Area Health Board.**—The term “area health board” means a regional health board, a district health board, or a community health board established under this Act.

(4) **Area-related Terms.**—

(A) **Community.**—The term “community” means a health care delivery community established under title I.

(B) **District.**—The term “district” means a health care delivery district established under title I.

(C) **Region.**—The term “region” means a health care delivery region established under title I.

(D) **Area.**—The term “area” means, with respect to an area health board or an area health care facility—

(i) in the case of a community board or a health care facility established by a
community board, the community for
which such board is established or in which
the facility is located;

(ii) in the case of a district board or
a health care facility established by a dis-
trict board, the district for which such
board is established or in which the facility
is located; and

(iii) in the case of a regional board or
a health care facility established by a re-
gional board, the region for which such
board is established or in which the facility
is located.

(5) Local board-related terms.—

(A) Interim regional board.—The
term “interim regional board” means an in-
terim regional health board established in ac-
cordance with section 112.

(B) Regional board.—The term “re-
gional board” means a regional health board es-
tablished in accordance with title I.

(C) District board.—The term “district
board” means a district health board estab-
lished in accordance with title I.
(D) COMMUNITY BOARD.—The term “community board” means a community health board established in accordance with title I.

(6) REGIONAL AND DISTRICT BOARDS.—

(A) RESPECTIVE REGIONAL BOARD.—The terms “respective regional board” and “respective interim regional board” mean, with respect to a community board or a district board, the regional board or interim regional board, respectively, for the region which contains the community or district for which such community board or district board is established.

(B) RESPECTIVE DISTRICT BOARD.—The term “respective district board” means, with respect to a community board, the district board for the district which contains the community for which such community board is established.

(7) USER-RELATED TERMS.—

(A) USER.—The term “user” means an individual who is eligible under section 211 to receive health care services from the Service under this Act.

(B) REGISTERED USER.—The term “registered user” means, with respect to an area, a user who resides in the area and is registered
to vote in the area in general elections for Federal, State, or local officials.

(C) ELIGIBLE USER.—The term “eligible user” means, for purposes of sections 114 through 118, with respect to a community, district, or region, an individual who (i) is 18 years of age or older, (ii) resides in the community, district, or region, respectively, and (iii) is not a health worker (as defined in paragraph (8)(A)), an indirect provider of health care (as defined in subparagraph (E)), or a member of the immediate family of such a worker or indirect provider.

(D) USER MEMBER.—The term “user member” means, with respect to a health board, an eligible user elected or appointed by users or user members to the health board under sections 114 through 118.

(E) INDIRECT PROVIDER OF HEALTH CARE.—The term “indirect provider of health care” means an individual who—

(i) receives (either directly or through his or her spouse) more than one-tenth of his or her gross annual income from any one or combination of—
(I) fees or other compensation for provision of, research into, or instruction in, the provision of health care,

(II) entities engaged in the provision of health care or in such research or instruction,

(III) producing or supplying drugs, medical equipment, or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care, or

(IV) entities engaged in producing drugs, medical equipment, or such other articles;

(ii) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (i); or

(iii) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(8) WORKER-RELATED TERMS.—
(A) Health worker.—The term “health worker” includes—

(i) any employee of the Service; and

(ii) any individual who for remuneration delivers, administers any program in, provides supporting services for, teaches the subject matter of, or performs research in, health care services.

(B) Authorized health worker.—The term “authorized health worker” means, with respect to a specified health care service, an individual who is an employee of the Service and is authorized by a health board to deliver the service.

(C) Eligible area health worker.—The term “eligible area health worker” means, for purposes of sections 114 through 118 with respect to a community, district, or region, a health worker who is employed by the community, district, or regional health board (respectively) or, in the case of sections 114 through 117, is scheduled to be employed by such board on the effective date of health services.

(D) Worker member.—The term “worker member” means, with respect to a health
board, an eligible area health worker elected or appointed by health workers or worker members to the health board under sections 114 through 118.

(9) FACILITY-RELATED TERMS.—

(A) HEALTH CARE FACILITY.—The term “health care facility” means an administrative unit composed of specified staff, equipment, and premises and established by a health board as an appropriate unit of organization for the delivery of specified health care or supplemental services under this Act.

(B) AREA HEALTH CARE FACILITY.—The term “area health care facility” means, with respect to an area health board, a health care facility established by the area health board.

(10) SERVICE-RELATED TERMS.—

(A) HEALTH CARE SERVICES.—The term “health care services” means the services described in paragraphs (1) through (5) of section 213(a).

(B) SUPPLEMENTAL SERVICES.—The term “supplemental services” means the services described in paragraphs (1), (2), and (3) of section 213(b).
(11) **NUMBER OF RESIDENTS.**—The term “number of residents” means the number of residents in a health care delivery area as determined by the most recent decennial national census.

(12) **EFFECTIVE DATE OF HEALTH SERVICES.**—The term “effective date of health services” means the effective date of health services under this Act as specified in section 601.

**TITLE I—ESTABLISHMENT AND OPERATION OF THE UNITED STATES HEALTH SERVICE**

**Subtitle A—Initial Organization**

**SEC. 101. ESTABLISHMENT OF THE SERVICE.**

(a) **IN GENERAL.**—There is established, as an independent establishment of the executive branch of the United States, the United States Health Service.

(b) **AUTHORITY.**—

(1) **NATIONAL HEALTH BOARD.**—The authority of the Service shall be exercised by the appropriate National Health Board and, in accordance with this Act and guidelines established by such Board, by area health boards.

(2) **EMINENT DOMAIN AUTHORITY.**—The Service shall have the authority, under the power of eminent domain, to acquire by condemnation under ju-
死刑的程序，以供服务用于公共目的，必要或有利时，须如此进行。

SEC. 102. APPOINTMENT OF INTERIM NATIONAL HEALTH BOARD.

(a) IN GENERAL.—The President shall, no later than 30 days after the date of the enactment of this Act, appoint 21 individuals—

(1) who are 18 years of age or older;

(2) who are concerned about the health care problems of the Nation;

(3) who approximate the Nation’s population by race, sex, income, language, and region of residence, and approximate the percentage of rural and frontier populations; and

(4) no more than seven of whom are or have been health workers, indirect providers of health care, or members of the immediate family of such workers or indirect providers within 24 months of the date of such nomination.

To serve as members of the Interim National Health Board of the Service.

(b) DESIGNATION OF CHAIRPERSON AND VICE CHAIRPERSON.—The President shall, at the time of such appointments, designate two nominees to the Interim Na-
tional Health Board who are not and have not been health
workers, indirect providers of health care, or members of
the immediate family of such workers or indirect providers
within 24 months of the date of such appointment as
chairperson and vice chairperson of such Board.

SEC. 103. POWERS AND DUTIES OF THE INTERIM NATIONAL
HEALTH BOARD.

(a) Term.—The members of the Interim National
Health Board shall serve as the National Health Board
of the Service until the National Health Board holds its
initial meeting in accordance with section 117(c)(2).

(b) Duties.—The Interim National Health Board
shall—

(1) establish the boundaries of health care de-
delivery regions, in accordance with section 111;

(2) select interim regional health boards in ac-
cordance with section 111;

(3) assist interim regional health boards in the
performance of their functions;

(4) coordinate the initial election of community
health boards, under section 114; and

(5) carry out such duties of the National
Health Board as it deems necessary and consistent
with the timetable given under this Act and the pur-
poses of the Service, except that no staff member
may be appointed and no employee may be hired by
the Interim National Health Board for a period ex-
tending beyond 90 days after the appointment of the
National Health Board under section 117.

(c) Application of Requirements.—The Interim
National Health Board shall operate in a manner con-
sistent with the provisions of subtitle C.

(d) Initial Report.—The Interim National Health
Board shall submit a report to Congress on its perform-
ance under this Act no later than 30 days after the ap-
pointment of the National Health Board under section
117.


There are authorized to be appropriated to the Serv-
$4,000,000,000 to carry out the provisions of this Act
with respect to the establishment of the Service. Funds
appropriated under this section shall remain available
until expended.

Subtitle B—Organization of Area
Health Boards

SEC. 111. Establishment of Health Care Delivery Re-
gions.

(a) Establishment of Health Care Delivery
Regions.—No later than 6 months after the appointment
of members of the Interim National Health Board, such
Board shall establish, in accordance with this section, health care delivery regions throughout the United States.

(b) REQUIREMENTS FOR DELIVERY REGIONS.—Each health care delivery region shall meet the following requirements:

(1) The region shall be a contiguous geographic area appropriate for the effective governance, planning, and delivery of all health care and supplemental services under this Act for residents of the region.

(2) The region shall have a population of not less than 500,000 and of not more than 3,000,000 individuals, except that—

(A) the population of a region may be more than 3,000,000 if the region includes a standard metropolitan statistical area (as determined by the Office of Management and Budget) with a population of more than three million; and

(B) the population of a region may be less than 500,000 if the Interim National Health Board determines that this is necessary to facilitate the delivery of health care and supplemental services or the effective governance of the health program within such region.
A region under subparagraph (B) may be a sparsely populated frontier area which consists of a very large or multi-state geographic area.

(3) The boundaries of each region shall take into account—

(A) any economic or geographic barrier to the receipt of health care and supplemental services in nonmetropolitan areas, and

(B) the differences in needs between non-metropolitan and metropolitan areas in the planning, development, and delivery of health care and supplemental services.

(c) Process.—At least 60 days prior to the establishment of the boundaries of any region, the Interim National Health Board shall provide for—

(1) notice in the area which would be affected by the establishment of such boundaries of the boundaries proposed to be established, and of the date, time, and location of the public hearing on such establishment as provided in paragraph (2); and

(2) a public hearing at which individuals can speak or present written statements relating to the establishment of such boundaries.
(d) Modification of Boundaries.—The boundaries of regions shall be modified in accordance with section 119.

SEC. 112. APPOINTMENT OF INTERIM REGIONAL HEALTH BOARDS.

(a) Appointment of Interim Regional Boards.—No later than 60 days after the establishment of health care delivery regions under section 111, the Interim National Health Board shall appoint an interim regional board for each such region.

(b) Composition.—Each interim regional board shall be composed of nine members—

(1) who are 18 years of age or older;

(2) who are concerned about the health care problems of their region;

(3) who approximate the region’s population by race, sex, income, and language; and

(4) no more than three of whom are or have been health workers, indirect providers or health care, or members of the immediate family of such workers or indirect providers within 24 months of the date of such appointment.

(e) Designation of Chairperson and Vice Chairperson.—The Interim National Health Board shall, at the time of appointment of each interim regional
board, designate two members of the board who are not
and have not been health workers, indirect providers of
health care, or members of the immediate family of such
workers or indirect providers within 24 months of the date
of such appointment as chairperson and vice chairperson
of such board.

(d) VACANCIES.—A vacancy in the membership of an
interim regional board shall be filled in the same manner
as the original appointment.

(e) TERM.—The members of an interim regional
board shall serve until the certification of appointment of
a regional board in its region in accordance with section
116.

(f) DUTIES.—Each interim regional board shall—

(1) establish the boundaries of health care de-
livery districts and of health care delivery commu-
nities within its region in accordance with section
113;

(2) conduct elections for voting members of
community boards within its region, in accordance
with section 114; and

(3) carry out such functions of a regional
board, set out under this Act, as the Interim Na-
tional Health Board deems appropriate for the pur-
poses of this Act.
Operational Requirements.—Each interim regional board shall operate in a manner in accordance with subtitle C of this title.

SEC. 113. ESTABLISHMENT OF HEALTH CARE DELIVERY DISTRICTS AND HEALTH CARE DELIVERY COMMUNITIES.

(a) In General.—No later than 6 months after its appointment under section 112, each interim regional board shall establish, in accordance with this section, health care delivery districts and health care delivery communities throughout its region.

(b) Division Into Districts.—Each region shall be divided into three or more health care delivery districts. Each such district shall meet the following requirements:

(1) The district shall be a contiguous geographic area appropriate for the effective governance, planning, and delivery of all health care services, except for highly specialized health services, for residents of such district.

(2) The district shall have a population of not less than 100,000 and of not more than 500,000 individuals, except that a district may have a population of less than 100,000 if the interim regional board or regional board (as appropriate) determines that a lesser population would facilitate the delivery
of health care and supplemental services or the ef-

tective governance of the health program within such
district or its region.

(c) DIVISION OF DISTRICTS INTO COMMUNITIES.—

Each district shall be divided into three or more health
care delivery communities. Each such community shall
meet the following requirements:

(1) The community shall be a contiguous geo-

craphic area appropriate for the effective govern-
ance, planning, and delivery of comprehensive pri-
mary health care services, described in section
221(a)(2), for residents of such community.

(2) The residents of the community shall, to the
maximum extent feasible, have a commonality of in-
terest, language, and ethnic and racial composition
sufficient to support and maintain a community
health program under this Act.

(3) The community shall have a population of
not less than 25,000 and of not more than 50,000
individuals, except in the case of Indian reservations
and, except that a community may have a population
of less than 25,000 if the interim regional board or
regional board (as appropriate) determines that a
lesser population would facilitate the delivery of
health care and supplemental services or the effec-
tive governance of the health program within such community or the district in which it is located.

(d) PROCESS.—At least 60 days prior to the establishment of the boundaries of any district or community within its region, the interim regional board shall provide for—

(1) notice in the district or community which would be affected by the establishment of such boundaries of the boundaries proposed to be established and of the date, time, and location of the public hearing on such establishment as provided in paragraph (2); and

(2) a public hearing at which individuals residing within the region can speak or present written statements relating to the establishment of such boundaries.

(e) PROCESS FOR MODIFICATION OF BOUNDARIES.—The boundaries of districts and communities shall be modified in accordance with section 119.

SEC. 114. ELECTION OF COMMUNITY HEALTH BOARDS.

(a) IN GENERAL.—

(1) USER MEMBERS.—The Interim National Health Board shall arrange with State and local governments for the initial elections for user members of each community board to be held on a date
not later than 9 months after the appointment of inter-

tem regional boards under section 112.

(2) Worker members.—Elections for worker

members of each community board shall first be held

as soon as possible after the selection of health

workers for employment by the user members of

such community boards. Such elections shall be held,
to the extent feasible, in accordance with subsection

e(2)(B).

(b) Number.—

(1) User members.—The number of user

members to be elected in an election in a community

under subsection (a) shall be six, plus one user

member for each 5,000 individuals residing in such

community in excess of 30,000 residents.

(2) Worker members.—The number of work-

er members to be elected in an election in a commu-

nity under subsection (a) shall be three, plus one

member for each 10,000 individuals residing in such

community in excess of 30,000 residents.

(c) Nomination and Election Procedures.—

(1) In general.—The Interim National

Health Board shall establish procedures for the

nomination and election under this section of user

members of community boards and worker members
of area health boards. Each interim regional board shall conduct and supervise such nominations and elections in its region in accordance with such procedures.

(2) Nomination process.—

(A) User members.—Such procedures for election of user members shall provide, except as otherwise provided in this subtitle, for—

(i) the nomination for election as a user member to a community board of any eligible user, upon presentation to the respective interim regional board of a petition or petitions signed by at least one percent of the registered users in the community;

(ii) the full disclosure by each nominee, at the time of presentation of a petition or petitions under clause (i), to the respective interim regional board of any financial interest of the nominee and such nominee’s family in the delivery of health care services, in research on health or health care services, or in the provision of drugs or medical supplies;
(iii) the opportunity, regardless of race, sex, language, income level, or health condition, for all registered users in each such community to nominate eligible users for, and for all eligible users in each such community to run for and to serve as user members of, such users’ community board;

(iv) the right of all registered users in each such community, regardless of race, sex, language, income level, or health condition, to vote in elections for user members of such users’ community board, and the right of registered users who are not physically or mentally capable of voting themselves to designate other registered users to vote proxies on their behalf;

(v) public meetings sponsored by the respective interim regional board in each such community within its region, at which all users nominated for election to the community board in the community may present their views;

(vi) the preparation and distribution within each such community by the respective interim regional board of literature
presenting the qualifications and views of,
and disclosing information described in
clause (ii) for, each nominee for election as
a user member of the community board in
the community; and

(vii) the election of the nominees re-
ceiving the greatest number of votes.

(B) WORKER MEMBERS.—Such procedures
for election of worker members shall provide
for—

(i) the nomination for election as a
worker member of an area health board of
any eligible area health worker, upon pres-
entation to the respective interim regional
board of a petition (or petitions) signed by
at least 1 percent of the eligible area
health workers, and

(ii) the full participation of eligible
area health workers of all job categories
and skill levels in the nomination and elec-
tion process.

(d) CERTIFICATION.—

(1) IN GENERAL.—Unless an election is set
aside under section 402(d)(1) (relating to grievance
procedures), individuals who have been elected to a
community board for a community under this section, including user members until worker members have been elected, shall be certified by the interim regional board as constituting, on the date of such certification, the community board for the community.

(2) INITIAL MEETING.—With respect to each group of individuals constituting a community board under paragraph (1), the respective interim regional board shall select a time, date, and location within the community of such community board for the holding of the initial meeting of such community board, which date shall not be later than 30 days after the date of the election, and shall notify the newly elected and approved members of such board and the residents of such community of the time, date, and location of such meeting.

SEC. 115. APPOINTMENT OF DISTRICT HEALTH BOARDS.

(a) INITIAL APPOINTMENT.—

(1) USER MEMBERS.—Not later than 60 days after the initial meeting of each community board, called pursuant to section 114(d)(2), the user members of each such board shall appoint two eligible users in the community to serve as user members of their respective district board.
(2) Worker members.—As soon as feasible, the worker members of each such board shall appoint an eligible community health worker to serve as a worker member of their respective district board.

(3) Worker members.—As soon as feasible, the eligible district health workers shall, in accordance with section 114(c)(2)(B), elect an eligible district health worker to serve as a worker member of their respective district board.

(4) Notice of appointment.—The user and worker members of each such community board shall promptly notify their respective interim regional board of appointments under this subsection.

(b) Certification.—

(1) In general.—Not later than 15 days after the date a majority of the initial community boards within a district have notified their respective interim regional board of the appointment of user members for their respective district boards under subsection (a)(1), such interim regional board shall certify the users so appointed as constituting, on the date of such certification, the district board for the district.
(2) Initial Meeting.—With respect to each district board certified under paragraph (1), its respective interim regional board shall select a time, date, and location within the district of such district board for the holding of the initial meeting of such district board, which date shall not be later than 15 days after the date of such certification, and shall notify the approved members of such board and the residents of such district of the time, date, and location of such meeting.

SEC. 116. APPOINTMENT OF REGIONAL HEALTH BOARDS.

(a) In General.—

(1) User Members.—Not later than 60 days after the initial meeting of each district board, called pursuant to section 115(b)(2), the user members of each such board shall appoint two eligible users in the district to serve as user members of their respective regional board.

(2) Appointment of Worker Member.—As soon as feasible, the worker members of each such board shall appoint an eligible district (or community, in the district) health worker to serve as a worker member of their respective regional board.

(3) Election of Worker Member.—As soon as feasible, the eligible regional health workers shall,
in accordance with section 114(e)(2)(B), elect an eligible regional health worker to serve as a worker member of their respective regional board.

(4) NOTICE.—The user and worker members of each such district board shall promptly notify their respective interim regional board and the Interim National Health Board of such appointments.

(b) CERTIFICATION.—

(1) IN GENERAL.—Not later than 15 days after the date a majority of the initial certified district boards within a region have notified their respective interim regional board of the appointment of user members for their respective regional board under subsection (a)(1), such interim regional board shall certify the users so appointed as constituting, on the date of such certification, the regional board for the region.

(2) INITIAL MEETING.—With respect to each regional board certified under paragraph (1), the interim regional board that certified such board shall select a time, date, and location within its region for the holding of the initial meeting of such regional board, which date shall not be later than 15 days after the date of such certification, and shall notify the appointed and approved members of such board...
and the residents of its region of the time, date, and location of such meeting.

SEC. 117. APPOINTMENT OF THE NATIONAL HEALTH BOARD.

(a) ASSIGNMENT OF REGIONS.—The Interim National Health Board shall, for purposes of appointing members of the National Health Board, assign each region to one of three groups of regions, each group having (to the extent possible) an equal number and balanced geographic distribution of regions.

(b) APPOINTMENT OF MEMBERS.—

(1) USER MEMBER.—Not later than 60 days after the initial meeting of each regional board, called pursuant to section 116(b)(2), each such board for a region in the first two groups of regions (established under subsection (a)) shall appoint (subject to the approval of the President) an eligible user in the region to serve as a user member of the National Health Board.

(2) WORKER MEMBER.—As soon as feasible, each such board for any other region shall appoint (subject to approval of the President) an eligible regional (or community or district, in the region) health worker to serve as a worker member of the National Health Board.
(3) Notice and review.—Each regional board shall promptly notify the Interim National Health Board and the President of each appointment under this subsection. The President shall approve or disapprove the appointment of such a member within the 10-day period beginning on the date of his notification of the appointment; and the appointment of such a member shall be considered as having been approved by the President unless he disapproves the appointment of the member within such time period.

(c) Certification.—

(1) In general.—No later than 15 days after the date a majority of the appointments under subsection (b)(1) by initially certified regional boards have been approved by the President, the Interim National Health Board shall certify the individuals so approved as constituting, on the date of such certification, the National Health Board, and shall promptly notify the President and the Congress of such certification.

(2) Initial meeting.—The Interim National Health Board shall select a time, date, and location for the holding of the initial meeting of the National Health Board, which date shall not be later than 15 days after the date of the certification under para-
graph (1), and shall notify appointed and approved members and the public of the time, date, and location of such meeting.

SEC. 118. SUBSEQUENT ELECTION AND APPOINTMENT OF MEMBERS OF HEALTH BOARDS.

(a) TERMS.—Members of health boards elected or appointed in accordance with sections 114 through 117 shall serve until their successors are certified in accordance with this section.

(b) ELECTIONS.—

(1) USER MEMBERS.—The National Health Board shall arrange with State and local governments for an election for user members of each community board to be held on the date of, and in conjunction with, each election for Members of the United States House of Representatives that occurs after the effective date of health services.

(2) WORKER MEMBERS.—An election for worker members of each community board shall be held on or about the date of each election specified in paragraph (1) and shall be held, to the extent feasible and consistent with section 114(c)(2)(B), in conjunction with the election under paragraph (1).

(3) PROCESS.—The provisions of section 114 (other than subsection (a) thereof) shall apply to
elections of members of community boards under this subsection, except that for purposes of this subsection—

(A) the term of each member elected under this subsection shall be 4 years, except that, in the case of the elections first held under this section, the term of half of the user members and of half of the worker members or, in the case of an odd number of user or worker members, the term of half plus one of such members shall be 2 years;

(B) the individuals whose term of office does not expire following an election, as well as individuals elected in the election, are deemed to constitute the community board under section 114(d)(1); and

(C) any reference to an interim regional board or to the Interim National Health Board in section 114 shall be considered as a reference to a regional board or to the National Health Board.

(c) COMMUNITIES.—

(1) ASSIGNMENT.—Each regional board shall, for purposes of appointing worker members of district boards within its region, assign each commu-
nity to one of two groups of communities within each district, each group having (to the extent possible) an equal number and balanced geographic distribution of communities.

(2) APPOINTMENT.—Not later than 60 days after the initial meeting of each community board (newly certified after an election under subsection (b))—

(A) in the case of the first new certification of such a board—

(i) user members of each such board shall appoint two eligible users in the community, one of whom shall serve a 4-year term as a user member of their respective district board and the other a 2-year term on such board; and

(ii) worker members of each such board for a community in the first group of communities (established under paragraph (1)) shall appoint an eligible community health worker to serve a 4-year term as a worker member of their respective district board, and worker members of each such board for a community in the second group of communities shall appoint
an eligible community health worker to
serve a 2-year term on such board;
(B) in the case of a subsequent new certifi-
cation of such a board—
   (i) user members of each such board
shall appoint an eligible user for a 4-year
term; and
   (ii) worker members of each such
board for a community in a group of com-
munities that did not appoint a worker
member to serve a 4-year term after the
previous certification shall appoint an eligi-
ble community health worker to serve a 4-
year term; and
(C) beginning with the first new certifi-
cation of such a board, and every 4 years there-
after, the eligible district health workers shall,
in accordance with section 114(c)(2)(B), elect
an eligible district health worker to serve a 4-
year term as a worker member of their respec-
tive district board.
The user and worker members of each such com-
nity board shall promptly notify their respective re-
gional board of such appointments.
(3) Certification.—Not later than 15 days after the date a majority of the newly certified community boards within a district have notified their respective regional board of the appointment or election of individuals for their respective district boards under paragraph (2), such regional board shall certify the users and workers whose term of office does not expire at the time of such appointments or elections, as well as individuals newly appointed or elected, as constituting, on the date of such certification, the district board for the district.

(4) Initial Meeting.—For each district board certified under paragraph (3), the respective regional board shall select a time, date, and location within the district of such district board for the holding of the initial meeting of such new board, which date shall be not later than 15 days after the date of such certification, and shall notify the members of such board appointed under this subsection and the residents of the district of the time, date, and location of such meeting.

(d) Districts.—

(1) Assignment.—The National Health Board shall, for purposes of appointing worker members of regional boards, assign each district to one of two
groups of districts within each region, each group having (to the extent possible) an equal number and balanced geographic distribution of districts.

(2) APPOINTMENT.—Not later than 60 days after the initial meeting of each newly certified district board (held pursuant to subsection (c)(4))—

(A) in the case of the first new certification of such a board—

(i) user members of each such board shall appoint two eligible users in the district, one of whom shall serve a 4-year term as a user member of their respective regional board and the other a 2-year term on such board; and

(ii) worker members of each such board for a district in the first group of districts (established under paragraph (1)) shall appoint an eligible district (or community, within the district) health worker to serve a 4-year term as a worker member of their respective regional board, and worker members of each such board for a district in the second group of districts shall appoint an eligible district (or com-
munity, within the district) health worker
to serve a 2-year term on such board;
(B) in the case of a subsequent new certifi-
cation of such a board—
(i) user members of each such board shall
appoint an eligible user for a 4-year term; and
(ii) worker members of each such
board for a district in a group of districts
that did not appoint a worker member to
serve a 4-year term after the previous cer-
tification shall appoint an eligible district
(or community, within the district) health
worker to serve a 4-year term; and
(C) beginning with the first new certifi-
cation of such a board, and every 4 years there-
after, the eligible regional health workers shall,
in accordance with section 114(c)(2)(B), elect
an eligible regional health worker to serve a 4-
year term as a worker member of their respec-
tive regional board.

The user and worker members of each such district
board shall promptly notify the National Health
Board of such appointments.

(3) CERTIFICATION.—Not later than 15 days
after the date a majority of the newly certified dis-
trict boards within a region have notified the Na-
tional Health Board of the appointment or election
of individuals for their respective regional boards
under paragraph (2), the National Health Board
shall certify the users and workers whose term of of-
office does not expire at the time of such appoint-
ments or elections, as well as individuals newly ap-
pointed or elected, as constituting, on the date of
such certification, the regional board for the region.

(4) INITIAL MEETING.—For each regional
board newly certified under paragraph (3), the pre-
viously certified regional board shall select a time,
date, and location within the region for the holding
of the initial meeting of such new board, which date
shall not be later than 15 days after the date of
such certification, and shall notify the members of
such board appointed and approved under this sub-
section and the residents of the region of the time,
date, and location of such meeting.

(e) NATIONAL HEALTH BOARD.—

(1) APPOINTMENTS.—Not later than 60 days
after the initial meeting of each newly certified re-
gional board, held pursuant to subsection (d)(4)—

(A) in the case of the first new certifi-
cation of such a board—
(i) each such board for a region in the first group of regions (established under section 117(a)) shall appoint (subject to the approval of the President) an eligible regional (or community or district, in the region) health worker, and

(ii) each such board for any other region shall appoint (subject to the approval of the President) an eligible user in the region,

to serve a 4-year term as a member of the National Health Board; and

(B) in the case of a subsequent new certification of such a board occurring when the terms of office of members of the National Health Board are expiring—

(i) each such board for a region in a group of regions that has appointed an eligible user to serve as a member of the National Board for the previous two appointments under this subsection or section 117(b) shall appoint (subject to the approval of the President) an eligible regional (or community or district, in the region) health worker, and
(ii) each such board for any other re-
gion shall appoint (subject to the approval
of the President) an eligible user in the re-
gion,

to serve a 4-year term as a member of the Na-
tional Health Board.

Each such board shall promptly notify the National
Health Board and the President of such appoint-
ment. The President shall approve or disapprove the
appointment of such a member within the 10-day
period beginning on the date of his notification of
the appointment; and the appointment of such a
member shall be considered as having been approved
by the President unless he disapproves the appoint-
ment of the member within such time period.

(2) CERTIFICATION.—No later than 15 days
after the date a majority of the appointments under
paragraph (1) by newly certified regional boards
have been approved by the President, the National
Health Board shall certify the individuals so ap-
proved as constituting, on the date of such certifi-
cation, the National Health Board and shall prompt-
ly notify the President and Congress of such certifi-
cation.
(3) **INITIAL MEETING.**—The previously certified National Health Board shall select a time, date, and location for the holding of the initial meeting of the new National Health Board, which date shall not be later than 15 days after the date of certification of such Board under paragraph (2), and shall notify the members appointed and approved under this subsection and the public of the time, date, and location of such meeting.

**SEC. 119. MODIFICATION OF THE BOUNDARIES OF HEALTH CARE DELIVERY AREAS.**

(a) **IN GENERAL.**—No later than 2 years after each decennial national census, and at such other times as it deems necessary, the National Health Board shall review the appropriateness of the boundaries of each health care delivery region and may, in accordance with subsection (b), modify the boundary of any region in which there has been a substantial shift of population justifying such modification, if such modification is approved in a referendum of registered users residing in an area whose regional identification would be changed by making such modification.

(b) **PROCESS.**—At least 60 days before the modification by referendum of the boundary of any region, the National Health Board shall provide for—
(1) notice in the area whose regional identification would be changed by the modification of such boundaries—

(A) of existing boundaries and of the proposed modification, and

(B) of the date, time, and location of the public hearing on such modification, as required in paragraph (2), and

(2) a public hearing at which individuals can speak or present written statements relating to the modification of such boundaries.

(c) Review of Appropriateness.—

(1) In general.—After the establishment of regional health boards under section 116—

(A) no later than 2 years after each decennial national census,

(B) upon receipt of a petition for modification of a boundary of a district or community within the region of such board, which petition is signed by not less than 15 percent (or 10 percent, in the case of a region where more than one-third of the geographic area includes frontier communities, of the residents residing in the frontier portion of the region) of the registered users residing in an area whose district
or community identification would be changed by adoption of such petition, and

(C) at such other times as it deems appropriate,

each regional board shall review the appropriateness of the boundaries of districts and communities within its region.

(2) Process.—Any review conducted under paragraph (1) shall comply with the procedures of subsection (d) (relating to open hearings and public participation).

(3) Standards for Modification.—A regional board, after reviewing the boundaries of a district or community within its region under paragraph (1), may modify the boundary of any such district or community if—

(A) there has been a substantial shift of population justifying such modification, or

(B) such modification would better carry out the purposes of this Act, and

if such modification is approved in a referendum, held after notice and a public hearing in accordance with subsection (d), of registered users residing in an area whose district or community identification
would be changed by adoption of the proposed modification.

(d) PROCESS.—At least 60 days before the modification by referendum of the boundary of any district or community, the respective regional board shall provide for—

(1) notice in the area whose district or community identification would be changed by the modification of such boundaries—

(A) of existing boundaries and of the boundaries proposed to be modified, and

(B) of the date, time, and location of the public hearing on such modification, as required in paragraph (2), and

(2) a public hearing at which individuals can speak or present written statements relating to the modification of such boundaries.

Subtitle C—General Provisions Regarding Health Boards

SEC. 121. DEFINITIONS.

As used in this subtitle, the term “full member” means, with respect to a health board, a member of such board other than an associate member described in section 122(a)(4).
Sec. 122. Membership of Health Boards.

(a) Composition.—Each health board shall be composed of—

(1) members elected or appointed and approved in accordance with this subtitle B;

(2) one member—

(A) in the case of a community board, appointed by the occupational safety and health action council established under section 412 for such community, and

(B) in the case of a regional board, appointed by the occupational safety and health action council established under section 413 for such region;

(3) such voting user members as the members of the board described in paragraphs (1) and (2) may determine from time to time (in consultation with elements of the population from which the members are being selected) to be necessary in order to ensure that (A) the user members of the board approximate the population within its area by race, sex, income level, and language and (B) segments of the population having special health needs (such as the physically and mentally handicapped and the aged) are appropriately represented; and
(4) such nonvoting associate members as the members of such board may determine from time to time to be necessary to provide appropriate representation of appropriate units of State, territorial, and local government and of segments of the population having special health needs; and in the case of the Interim National Health Board and National Health Board, to carry out the purposes of this Act.

(b) Term Limits.—

(1) In general.—Except as provided in paragraph (2), no individual may serve as a full member of a health board in a community, district, or region, or of the National Health Board, for more than four consecutive years, exclusive of any time that might be served as a member by election or appointment (A) before the effective date of health services, (B) for a 2-year term under section 118(b)(3)(A), 118(c)(2)(A), or 118(d)(2)(A), or (C) by appointment under subsection (d) to fill a vacancy.

(2) Exception.—Full members of a health board shall serve until their successors are certified in accordance with this Act.

(e) —

(1) Recall elections.—
(A) IN GENERAL.—Within 60 days of the
date of the presentation to the appropriate re-
gional board of a petition, signed by at least 15
percent of the number of registered users resid-
ing in a community or of eligible area health
workers, requesting the recall of a user member
or elected worker member, respectively, of a
board elected and approved in accordance with
this title, such regional board shall conduct an
election on the recall of such member.

(B) PROCESS.—The provisions of section
114 (except for subsection (a) thereof) and pro-
cedures established thereunder regarding elec-
tions of user and worker members shall apply
with respect to recall elections conducted under
this paragraph, except that for the purposes of
this paragraph, any reference in such section to
an interim regional board or to the Interim Na-
tional Health Board shall be considered as a
reference to a regional board or to the National
Health Board, respectively.

(2) VOTE REQUIRED.—A member of a district
or regional board or an interim regional board ap-
pointed in accordance with this title may be recalled
from office by the affirmative vote of two-thirds of
the members of the health board which appointed
such member.

(3) Removal of National Health Board
Member.—A member of the Interim National
Health Board or National Health Board may be re-
moved from office by the President for neglect of
duty, malfeasance in office, or, in the case of the
National Health Board, upon recommendation by
the affirmative vote of two-thirds of the members of
the regional board which nominated such member.

(d) Vacancies.—

(1) In General.—A vacancy caused by the
death, resignation, or removal of a member (in this
subsection referred to as a “vacating member”) of a
health board, elected or appointed in accordance
with this title, before the expiration of the term for
which such vacating member was elected or ap-
pointed, shall be filled not later than 60 days after
the date of such vacancy—

(A) in the case of a member of a commu-
nity board, by election of an eligible individual,
in accordance with section 114 (except for sub-
section (a) thereof);

(B) in the case of a member of a district
or regional board, an interim regional board, or
the National Health Board, by appointment or
election and, in the case of the National Health
Board, Presidential approval of an eligible indi-
vidual by the health board or workers which ap-
pointed or elected such vacating member; and

(C) in the case of a member of the Interim
National Health Board, by appointment by the
President.

(2) TERM OF VACANCY APPOINTMENT.—Any
individual appointed to fill a vacancy under this sub-
section shall serve only for the unexpired term of of-
office of the vacating member.

(3) ELIGIBLE INDIVIDUAL DEFINED.—For the
purposes of this subsection, the term “eligible indi-
vidual” means, with respect to filling the place of a
vacating member, an individual who is eligible,
under the applicable provisions of this Act, to serve
on a health board in the capacity in which the
vacating member was elected or appointed.

SEC. 123. MEETINGS AND RECORDS OF HEALTH BOARDS.

(a) Full Member Rights.—

(1) Voting.—Each full member of a health
board shall have one vote in meetings of such board.

(2) Quorum.—A majority of the full members
of each health board shall constitute a quorum for
the transaction of the business of such board, and such board shall act upon the vote of a majority of the full members present and voting.

(b) Chairperson.—

(1) Election.—Except as otherwise provided in this Act, the full members of each health board shall, at the first meeting following the certification of such board, elect a chairperson and vice chairperson from among the full members of such board.

(2) Responsibilities.—The chairperson of each health board shall be responsible for convening meetings of such board and for such other duties as such board may assign. Upon the written request of two full members of such board, the chairperson shall convene a meeting of such board.

(3) Vice Chairperson.—The vice chairperson shall perform the duties of the chairperson in the event that the chairperson is unable to perform such functions.

(c) Records.—

(1) In general.—Each health board shall provide for the recording of the minutes of each of its meetings and each of the meetings of its committees and advisory groups, and shall make such records available to the public for inspection and copying.
(2) Access.—Meetings of each health board and each committee and advisory group thereof (except meetings that concern an individual user or health worker, and such individual requests that the meeting be closed) shall be open to the public and shall be held at such times and in such places as the board determines to be convenient to attendance by the public.

(3) Office.—Each health board shall establish a principal office within the area it serves.

(d) Dissemination of Information.—Each health board shall disseminate within the area it serves full information regarding its activities, including the furnishing of health care and supplemental services.

(e) Rules.—

(1) In General.—Each health board may establish such rules, consistent with this Act, as it finds necessary for the effective and expeditious transaction of its duties and functions.

(2) Committees.—Each health board may establish such committees and advisory groups, and appoint to them such individuals (including health workers), as it deems necessary to carry out its duties and functions.

(f) Compensation.—
(1) NATIONAL BOARD.—A full member of the Interim National Health Board or National Health Board may receive compensation at a rate not to exceed the daily equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which the member is engaged in the actual performance of such member’s duties plus reimbursement for travel, subsistence, and other necessary expenses incurred in the performance of such member’s duties.

(2) OTHER HEALTH BOARDS.—A full member of a health board, other than the Interim National Health Board of the National Health Board, may receive such amounts per diem when engaged in the actual performance of such member’s duties, or such annual salary, plus reimbursement for travel, subsistence, and other necessary expenses incurred in the performance of such member’s duties, as the appropriate National Health Board may establish.

SEC. 124. PROCEDURES FOR ESTABLISHMENT OF NATIONAL GUIDELINES AND STANDARDS.

(a) IN GENERAL.—In addition to guidelines and standards otherwise required to be established by this Act, the National Health Board shall establish by regulation (after notice and opportunity for public comment) such
guidelines and standards as will facilitate the implementation of the objectives of this Act and as will encourage innovation and experimentation in the implementation of these objectives.

(b) REVIEW.—The National Health Board shall submit, at least 90 days before the date of publishing a proposed guideline or standard under this Act, each such guideline or standard to regional boards for their review and comments.

(c) TECHNICAL ASSISTANCE.—The National Health Board and the regional boards shall establish programs that provide orientation, education, and technical assistance (including support staff) to members of area health boards in the use and application of guidelines and standards established by the National Health Board.

SEC. 125. ASSISTANCE TO AREA HEALTH BOARD MEMBERS.

Each regional board shall provide orientation, education, and technical assistance to members of district and community boards in its region, and the appropriate National Health Board shall provide such support to members of regional boards, to insure that such members are prepared to perform their duties as members of such boards with maximum effectiveness.
SEC. 126. PUBLIC ACCOUNTABILITY AND FINANCIAL DIS-CLOSURE BY HEALTH BOARD MEMBERS.

(a) Prohibition of Conflicts of Interest.—

(1) In General.—Individuals with direct or indirect conflicts of interest shall not serve on health boards at any level. Subject to paragraph (2), such conflicts may consist of ownership of, employment in, or other financial affiliation with any industry in a position to profit or otherwise benefit from the activities of the health board.

(2) Exception.—Paragraph (1) shall not apply to employment as a health worker by the Service as specified in this Act.

(b) Disclosure.—Candidates for health boards at any level shall fully disclose any such potential conflicts of interest, and if elected shall sever any affiliations that could result in a conflict. The severing of such ties shall be documented and reported to the National Health Board, which shall be accountable for monitoring and enforcing the provisions of this section.

SEC. 127. INSPECTOR GENERAL FOR HEALTH SERVICES.

Within the United States Health Service there shall be an Office of the Inspector General, to be headed by an Inspector General for Health Services, that shall have authority to ensure the effective operation of the health boards pursuant to this Act and to investigate and pursue
any grievances against such boards. The Inspector General shall have the same authority as an Inspector General has under the Inspector General Act of 1978.

TITLE II—DELIVERY OF HEALTH CARE AND SUPPLEMENTAL SERVICES

Subtitle A—Patients’ Rights in Health Care Delivery

SEC. 201. BASIC HEALTH RIGHTS.

The Service, in its delivery of health care services to users, shall ensure that every such individual is given the following basic health rights:

(1) The right to receive high quality health care and supplemental services from any facility within the Service capable of providing such services without charge and without discrimination on account of race, sex, age, religion, language, income, marital status, sexual orientation, dress, or previous health status.

(2) The right to humane, respectful, dignified, and comforting health care, and to the reduction of pain and distressful symptoms.

(3) The right to have all medically necessary or appropriate health services delivered in a convenient and timely manner. Any decision to deny or post-
pone such necessary or appropriate care shall be made only on the basis of temporary and reasonable limitations in the availability of service personnel and physical facilities. Users shall have the opportunity for timely and effective appeal of any decision to deny or postpone care.

(4) The right to choose the health workers who shall be responsible for, and the health facilities in which to receive, the individual’s health care services.

(5) The right of access to all information, including the individual’s health records and the medical dictionary produced under section 433(b), which promotes an understanding of health.

(6) The right to have all health care information, reports, and educational materials translated into the individual’s primary language.

(7) The right to receive, prior to the delivery of any health care service, a careful, prompt, and intelligible—

(A) explanation of the indications, diagnoses, benefits, side-effects, and risks involved in the delivery of such service, and a description of all medically necessary or appropriate alternatives to such service (including no treatment);
(B) answer to any question relating to
such health care service; and

(C) explanation of one’s health rights de-
scribed in this subtitle, and

the right to have such health care service delivered
only with the individual’s prior, voluntary, written
consent.

(8) The right to refuse the initial or continuing
delivery of any health care service whenever such re-
fusal does not directly endanger the public health or,
in accordance with State law, the health of the indi-
vidual if the individual is dangerous to himself or
herself.

(9) The right to have all individually identifi-
able information and documents treated confiden-
tially and not disclosed (except for statistical pur-
poses and for the control of communicable diseases,
drug abuse, and child abuse) without the individual’s
prior, voluntary, and written consent.

(10) The right of access at all times to individ-
uals or groups for counseling, health information,
and assistance on health matters, including access to
user advocates who shall—

(A) assist users in choosing the most ap-
propriate sites from which to receive health
services and the most appropriate health workers from whom to receive such services;

(B) provide counseling and assistance to users in filing complaints; and

(C) investigate instances of poor quality services or improper treatment of users and bring such instances to the attention of the applicable authority.

(11) The right to be accompanied and visited at any time by a friend, relative, or independent advocate of the individual’s choosing, and the right to have routine services, such as feeding, bathing, dressing, and bedding changes, performed by a friend or relative, if the individual so chooses.

(12) The right, in the event of terminal illness, to die with a maximum degree of dignity, to be provided all necessary symptom relief, to be provided (and for the individual’s family to be provided) counseling and comfort, and to be allowed (if desired) to die at home.

(13) The right of access to a complaint and grievance system and to legal assistance to enforce these rights.
SEC. 202. RIGHT TO PAID LEAVE TO RECEIVE HEALTH CARE SERVICES.

(a) Amendment to Fair Labor Standards Act.—The Fair Labor Standards Act of 1938 is amended by inserting after section 7 (29 U.S.C. 207) the following new section:

``MINIMUM HEALTH LEAVE COMPENSATION

``Sec. 7A. Each employee of any employer who in any workweek is engaged in commerce or in the production of goods for commerce, or is employed in an enterprise engaged in commerce or in the production of goods for commerce, shall be entitled to receive from the employer, for each 35 hours he is employed by the employer (not counting more than 35 hours in any workweek), compensation for one hour of employment at the regular rate at which the employee is employed (as that term is used in section 7 of this Act) for an hour (1) during the period of 52 weeks beginning with the workweek with which the entitlement is earned, and (2) during which the employee is unable to work because of the need for the employee (or a dependent of that employee) to receive necessary health care services.’’.

(b) Conforming Amendments.—The Fair Labor Standards Act of 1938 is further amended—

(1) by striking ‘‘sections 6 and 7’’ in section 3(o) and inserting ‘‘sections 6, 7, and 7A’’;
(2)(A) by striking “and 7” in section 13(a) before paragraph (1) and inserting “, 7, and 7A”;

(B) by striking “sections 6 and 7” in section 13(a)(3) and inserting “sections 6, 7, and 7A”;

(C) by inserting “7A,” in subsections (d) and (f) of section 13 after “7,” each place it appears;

(3) by striking “6 and 7” in section 14(d) and inserting “6, 7, and 7A”;

(4) by striking “section 6 or section 7” in section 15(a) and inserting “section 6, 7, or 7A”;

(5)(A) by striking “section 6 or section 7” in section 16(b) and inserting “section 6, 7, or 7A”;

(B) by striking “or their unpaid overtime compensation” in section 16(b) and inserting “their unpaid overtime compensation, or their unpaid health leave compensation”;

(C) by inserting “or of unpaid health leave compensation” in section 16(b) after “amount of unpaid overtime compensation”;

(D) by striking “section 6 or 7” in the first sentence of section 16(c) and inserting “section 6, 7, or 7A”;

(E) by striking “unpaid overtime compensation” in the first sentence of section 16(c) and in-
serting “, unpaid overtime compensation, or unpaid health leave compensation”;

(F) by striking “or overtime compensation” in the second sentence of section 16(c) and inserting “, overtime compensation, or health leave compensation”;

(G) by striking “or unpaid overtime compensation under sections 6 and 7” in the third sentence of section 16(c) and inserting “, unpaid overtime compensation, or unpaid health leave compensation under sections 6, 7, and 7A”;

(6)(A) by inserting “or minimum health leave compensation higher than the minimum health leave compensation established under this Act” in the first sentence of section 18(a) before “, and no provi-

sion”; and

(B) by inserting “, or justify any employer in reducing health leave compensation provided by him which is in excess of the applicable minimum health leave compensation under this Act” before the pe-

riod at the end of the second sentence of section 18(a).
Subtitle B—Eligibility for, Nature of, and Scope of Services Provided by the Service

SEC. 211. ELIGIBILITY FOR SERVICES.

(a) In General.—All individuals while within the United States are eligible to receive health care and supplemental services under this Act.

(b) UNITED STATES DEFINED.—For purposes of this section, the term “United States” includes Indian reservations, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, Samoa, and the Northern Mariana Islands.

SEC. 212. ENTITLEMENT TO SERVICES.

(a) In General.—Except as provided in subsection (b), the Service shall, on and after the effective date of health services, provide users with all health care services and supplemental services described in section 213 which the Service determines, in accordance with this title, to be necessary or appropriate for the promotion and enhancement of health, for the prevention of disease, and for the diagnosis and treatment of, and rehabilitation following, injury, disability, or disease.

(b) EXCLUSION.—Services provided under this Act shall not include personal comfort or cosmetic services unless the area health board providing the services deter-
mines that the services are required for health-related rea-
sons.

SEC. 213. PROVISION OF HEALTH CARE AND SUPPLE-
MENTAL SERVICES.

(a) In General.—The Service shall provide in the
United States the following health care services in or
through facilities established by the Service—

(1) the promotion of health and well-being
through health education programs to be carried out
in facilities of the Service as well as in workplaces,
schools, and elsewhere utilizing all appropriate
media, and by assisting other Government agencies
in taking appropriate actions to promote health and
well-being;

(2) the prevention of illness, injury, and death
through education and advocacy addressed to the so-
cial, occupational, and environmental causes of ill-
health; through the provision of appropriate preven-
tive services including social, medical, occupational,
and environmental health services, on both an emer-
gency and sustained basis; through screening and
other early detection programs to identify and ame-
liorate the primary causes of ill-health; and, where
appropriate, through actions taken on an emergency
basis to halt environmental threats to life and health;

(3) the diagnosis and treatment of illness and injury, including emergency medical services, comprehensive outpatient and inpatient health care services, occupational health services, mental health services, dental care, long-term care, and home health services;

(4) the rehabilitation of the sick and disabled, including physical, psychological, occupational, and other specialized therapies; and

(5) the provision of drugs, therapeutic devices, appliances, equipment, and other medical supplies (including eyeglasses, other visual aids, dental aids, hearing aids, and prosthetic devices) certified effective in the National Pharmacy and Medical Supply Formulary (published under section 432(a)) and furnished or prescribed by authorized health workers.

The Service may not provide such health care services in a region, district, or community other than under the auspices of a regional, district, or community board established in accordance with this Act.

(b) Supplemental Services.—The Service shall provide the following services supplemental to the delivery
of health care services in or through health care facilities established by the Service—

(1) ambulance and other transportation services to insure ready and timely access to necessary health care;

(2) child care services for individuals who, during the time they receive outpatient health care services from the Service or are working in a health care facility of the Service, are responsible for a child’s care; and

(3) homemaking and home health services—

(A) to enable the provision of inpatient health services at a health care facility of the Service to an individual who has the sole responsibility for the care (i) of a child under 15 years of age, or (ii) of a physically or mentally handicapped individual who requires the care of another individual, and

(B) for the bedfast or severely handicapped individual; and

(4) such counseling and social service assistance as will avoid the unnecessary provision of health care services.

(c) LOCAL PUBLIC HEALTH SERVICES.—The Service shall conduct the functions, especially those related to en-
vironmental health and the prevention of illness, currently
performed by the departments of health of the States and
localities, to the extent consistent with Federal, State, and
local law, and shall cooperate with State and local govern-
ments in its conduct of such functions.

(d) EMERGENCY HEALTH CARE SERVICES.—The
Service shall provide, at rates established by the National
Health Board, for reimbursement of the cost of emergency
health care services furnished in facilities not operated by
the Service or by health workers not employed by the Serv-
ice, when an injury or acute illness requires immediate
medical attention under circumstances making it medi-
cally impractical for the ill or injured individual to receive
care in a Service facility or by an employee of the Service.

Subtitle C—Health Care Facilities
and Delivery of Health Care
Services

SEC. 221. ESTABLISHMENT OF HEALTH CARE FACILITIES
AND DISTRIBUTION OF DELIVERY OF
HEALTH CARE AND OTHER SERVICES.

(a) COMMUNITY FACILITIES.—

(1) IN GENERAL.—Each community board
shall, not later than the effective date of health serv-
ices and to the maximum extent feasible, establish
and maintain in its community such health care fa-
ilities as are necessary for the efficient and effective
delivery to individuals residing in its community of
comprehensive primary health care services (defined
in paragraph (2)), specialized health care services
(defined in paragraph (3)), special services (defined
in paragraph (4)) and community-oriented health
measures (defined in paragraph (5)). Such health
care facilities shall be established and maintained in
a manner that, as soon as possible and to the great-
est extent feasible, provides services through a single
comprehensive health center.

(2) Comprehensive primary health care
services defined.—As used in paragraph (1), the
term “comprehensive primary health care services”
means those basic outpatient health care services
typically needed for the promotion of health and the
prevention and treatment of common illnesses and
includes the following health care services—

(A) general primary medical and dental
care, including diagnosis and treatment, routine
physical examinations, laboratory, and
radiologic services, and home visits by health
workers, as appropriate;

(B) preventive health services, including at
least immunizations, nutrition counseling and
consultation, and periodic screening and assessment services;

(C) children’s health services, including assessment of growth and development, education and counseling on childrearing and child development, and school and day-care center health services;

(D) obstetrical and gynecological services, including family planning and contraceptive services, pregnancy (prenatal and postnatal) and abortion counseling and services;

(E) comprehensive geriatric services;

(F) vision and hearing examinations and provision of eyeglasses and other visual aids and hearing aids;

(G) 24-hour emergency medical services;

(H) provision of pharmaceuticals and therapeutic devices, and medical appliances and equipment;

(I) mental health services, including psychological and psychiatric counseling;

(J) home health services; and

(K) occupational safety and health services, including screening, diagnosis, treatment, and education.
(3) Specialized health care services defined.—As used in paragraph (1), the term “specialized health care services” means those health care services of a specialized nature (whether delivered in an inpatient or outpatient setting) which, applying guidelines established by the National Health Board and by the respective regional board, may be provided most effectively and efficiently in a community setting.

(4) Special services defined.—As used in paragraph (1), the term “special services” means supportive services and the facilities (including nursing homes and multiservice centers) in which such services are provided for individuals who are physically or mentally handicapped, mentally ill, infirm, or chronically ill, so as to promote the integration and functioning of such individuals within the community.

(5) Community-oriented health measures defined.—As used in paragraph (1), the term “community-oriented health measures” includes efforts to focus organized community activities upon the promotion of health and the prevention of illness and injury, support for self-help and mutual aid groups offering health promotion and rehabilitative
support programs; surveillance of potential threats
to community health, and prompt action to protect
against such threats, and includes outreach efforts
to ensure that all residents are aware of and able to
utilize the health services of the Service, as needed.

(b) District Responsibilities.—Each district
board shall periodically determine the necessity to estab-
lish and maintain in its district inpatient and other spe-
cialized health care facilities. Where found appropriate, it
shall establish and maintain in its district—

(1) a general hospital for the efficient and ef-
fective delivery of health care services to individuals
residing in the district requiring inpatient diagnosis,
treatment, care, and rehabilitation for injury or ill-
ness; and

(2) such other health care facilities as are nec-
essary, using guidelines established by the National
Health Board and by the respective regional board,
to promote the efficient and effective delivery of
health care services within its district.

In addition, each district board shall provide such health
care services of a specialized nature (whether delivered in
an inpatient or outpatient setting) as, taking into account
guidelines established by the National Health Board and
its respective regional board, may be provided most effec-
tively and efficiently at the district level.

(c) **Regional Responsibilities.**—Each regional
board shall, not later than the effective date of health serv-
ices, establish and maintain in its region—

(1) a regional medical facility for the efficient
and effective delivery of highly specialized health
care services, using guidelines established by the Na-
tional Health Board, to individuals residing in the
region requiring highly specialized treatment, care,
and rehabilitation for injury or illness;

(2) health care and supplemental services for
individuals whose health care needs otherwise cannot
be met by community or district boards because of
occupational or other factors, including individuals
residing within the region on a temporary or sea-
sonal basis (including migratory agricultural work-
ers) and individuals confined to prisons and other
correctional institutions; and

(3) such other health care facilities as are nec-
essary to promote the efficient and effective delivery
of health care services within its region.

(d) **Area Health Board Responsibilities.**—
Each area health board, taking into account guidelines es-
tablished by the National Health Board, shall provide the
following through its health care facilities established pursuant to this section:

(1) Health promotion through education on personal health matters, nutrition, the avoidance of illness, and the effective use of health care services with particular emphasis on the appropriate and safe use (discouraging the overuse) of drugs and medical techniques.

(2) Maintenance and appropriate transmission and transferal of personal health records for each user of the services of the board consistent with section 201(9).

(3) Referral services, including referrals, where appropriate, to health care facilities established by other boards.

(4) Supplemental services (described in section 213(b)), as appropriate.

(5) Assistance to individuals who, because of language or cultural differences or educational or other handicaps, are unable fully to utilize the services available from and delivered by the board.

(6) Information (A) on the rights ensured under this Act, (B) on the guidelines and standards established by the appropriate National Health Board, and (C) on how the area health board is im-
plementing such rights and applying such guidelines and standards.

(7) Information on the grievance mechanisms established pursuant to subtitle A of title IV and on legal services available to pursue grievances against the board.

(8) Environmental health inspection and monitoring services, including investigations relating to the prevention of communicable diseases, in cooperation with State and local authorities in the board’s area.

(9) Research and data-gathering on the leading causes of ill-health and injury in the board’s area and on health care delivery, in accordance with section 421.

(10) In the case of each inpatient health care facility, discharge planning and followup services (A) to identify patients who will need continuing care after discharge from the facility and (B) to plan, with the patient and the patient’s family, arrangements and referrals to meet such postdischarge needs.

(e) AUTHORITIES.—

(1) EMPLOYMENT OF WORKERS.—Each area health board shall, in establishing health care facili-
ties under this section, hire health workers (including administrative personnel) in sufficient numbers and with appropriate qualifications to ensure that such facilities provide the health care and other services described in this section. The regional board shall be consulted in the hiring of all senior administrative and clinical personnel.

(2) FACILITIES.—In its establishment of health care facilities under this section, each area health board shall purchase or lease such premises as it deems necessary and suitable, utilizing, where appropriate, existing health facilities, including health centers and clinics, hospitals, nursing homes, and medical laboratories. The regional board shall be consulted in the purchase or leasing of such facilities.

(3) EFFECTIVE DELIVERY.—In its establishment of health care facilities under this section, each area health board shall seek to minimize fragmentation and duplication in delivery of health care and other services so as to promote the effective and efficient delivery of such services.

(4) COORDINATION.—Each regional board, taking into account guidelines established by the National Health Board, shall provide for affiliation and coordination of the operation and staff of the health
care facilities in its region with the operation and
staff of other appropriate health care facilities estab-
lished within the region such board serves and with-
in adjacent regions.

(5) ASSISTANCE TO COMMUNITY AND DISTRICT
HEALTH BOARDS.—Each regional board shall assist
the community and district health boards in its re-
gion in establishing and operating services. This
shall include providing for the education of health
workers under section 311, assistance in hiring all
health workers for the region, and assistance in pur-
chasing or leasing of such premises as it deems nec-
essary and suitable, in consultation with the appro-
priate community and district health boards in its
region.

(6) ASSURING AVAILABILITY AND ACCESSI-
BILITY OF SERVICES.—Each regional board shall,
taking into account guidelines established by the Na-
tional Health Board, take whatever additional steps
are necessary to ensure that all of the health serv-
ices required under this title are available and acces-
sible in a timely manner to adults, infants, children,
and individuals with disabilities in its region. To-
ward that end, it shall—
(A) ensure that users within its region have access to a sufficient number of each category of health worker, including primary care providers, specialists, and other health care professionals, in a manner so that, to the maximum extent possible, such providers are geographically accessible to all residences and workplaces within the region and are culturally and linguistically appropriate;

(B) ensure that services are available in a manner which ensures continuity of care, availability within reasonable hours of operation, and include emergency and urgent care services which shall be accessible at all times within the service area;

(C) ensure that any process established to coordinate care shall ensure ongoing direct access to relevant specialists and shall not impose an undue burden on users with chronic health conditions;

(D) ensure that appropriate steps are taken to eliminate any transportation or other barriers to the timely receipt of services;

(E) ensure that a user who has a severe, complex, or chronic condition shall have access
to the most appropriate health care coordinator
(as defined in paragraph (7)(A)); and

(F) ensure that priorities in the use of
services and facilities shall be set by the appro-
priate health care professionals using criteria of
medical necessity and that any limitations or
delay in access to services shall be based only
on limits of available service personnel and
physical facilities.

(7) DEFINITIONS.—For purposes of this sub-
section:

(A) HEALTH CARE COORDINATOR.—The
“health care coordinator” means a health work-
er who performs case management (as defined
in subparagraph (B)) functions in consultation
with the health care team, the patient, family,
and community.

(B) CASE MANAGEMENT.—The term “case
management” means a coordinated set of activi-
ties conducted for the management of an indi-
vidual user’s serious, complicated, protracted or
chronic health conditions in order to ensure
cost-effective and benefit-maximizing treatment.

(f) GUIDELINES.—The National Health Board shall
establish guidelines for distribution and coordination of
the delivery of health care and other services described in this section and shall, before the effective date of health services, plan and facilitate the transition to the new distribution of health care facilities and health workers to be effected on and after that date.

(g) Use of Evidence-Based Clinical Decision Criteria.—

(1) In General.—The National Health Board shall authorize the National Institute of Evaluative Clinical Research described in section 422 to establish evidence-based clinical decision criteria, where feasible, that shall apply throughout the Nation.

(2) Clinical Decision Criteria Defined.—For purposes of this section, the term “clinical decision criteria” means the recorded (written or otherwise) screening procedures, decision abstracts, clinical protocols, and practice guidelines used as an important basis to determine the necessity and appropriateness of health care services, in combination with the facts of particular cases, the judgment of health care professionals, and the preferences of users. Such criteria shall be clearly documented and available to all health workers and shall include a mechanism for periodically updating such criteria.
(h) **NOTICE OF DETERMINATIONS.**—Each health board shall provide users with timely notice of any determination to provide, deny, or delay provision of a service, and information about the relevant clinical decision criteria upon which such determination is based, if any. Such notification shall include information concerning the appropriate procedure to appeal such decision.

(i) **ACCOUNTABILITY.**—In the case that a community or district board fails, on the effective date of health services, to substantially and materially provide health care and supplemental services in accordance with this section, its respective regional board shall take such steps as it deems necessary, consistent with the provisions of section 402 (relating to grievance proceedings), to provide health care and supplemental services to users in the community or district affected. Such steps may include, in addition to appointment of a trustee or trustee committee under section 402(d)(3)(D)—

(1) requiring that the community or district board in an adjacent community or district provide such services to users residing in the community or district affected, or

(2) providing reimbursement for the provision of specified health care services in accordance with procedures and schedules in effect under title XVIII
of the Social Security Act immediately before the ef-
fective date of health services (except that only users
in the affected community or district shall be consid-
ered as entitled to receive such specified services
under such title).

Paragraph (2) shall not apply on and after three years
after the effective date of health services.

SEC. 222. OPERATION AND INSPECTION OF HEALTH CARE

FACILITIES.

(a) Establishment of Policies.—

(1) In general.—Each health board, with re-
spect to each health care facility it has established,
shall establish policies and organizational plans con-
sistent with this section and with parts A and C of
title III (relating to the health labor force) for the
operation of such facility and shall establish proce-
dures to ensure that the facility is operated in ac-
cordance with such policies and plans.

(2) Input.—In establishing, implementing, and
modifying such policies and plans, each health board
shall seek the fullest possible participation of health
workers who are employed in, and users who receive
health care services from, health care facilities af-
fected by such policies and plans.
(3) HEALTH FACILITY BOARDS.—If a health board that has established more than one health care facility determines that it cannot itself effectively manage the operation of all such facilities or if a facility serves principally a population with special health needs which is not appropriately represented on the health board, the health board may provide for the establishment of a health care facility board or boards, composed of users and health workers (or representatives of users or workers of a facility or facilities) in an appropriate number and in a proportion approximating that on the health board, to assume the duties of the health board with respect to the operation of the facility or facilities involved.

(b) GENERAL POLICY.—Such policies and plans shall provide for—

(1) the management of each facility by the workers in such facilities through mechanisms which provide full participation of health workers of all job categories and skill levels employed in such facility;

(2) the elimination of dominance by health professionals and the encouragement of cooperation and mutual respect among all health workers; and
(3) regular accountability of the health workers
to the health board which established the facility for
the efficient and effective operation of the facility.

(c) PRIVATE DELIVERY.—

(1) RESTRICTIONS.—On and after 3 years after
the effective date of health services, a health board
may not permit a health care facility it has estab-
lished to be used for the private delivery of inpatient
or outpatient health care services.

(2) EMPLOYMENT RESTRICTIONS.—No indi-
vidual employed by a health board may engage in
the private delivery of health care services.

(3) PRIVATE DELIVERY OF HEALTH CARE
SERVICES DEFINED.—For the purposes of this sub-
section, the term “private delivery of health care
services” means the delivery of health care services
for which an individual, group, or organization re-
ceives remuneration from any source other than the
Health Service Trust Fund established in section
511.

(d) HOURS OF OPERATION.—Each health board shall
ensure that any health care facility that it operates which
provides health care services on an outpatient basis is open
during hours that will permit all users to make use of such
services.
(c) Inpatient Services.—

(1) Adequate care.—Each health board shall ensure that any health care facility that it operates which provides (or is designed to provide) substantial health care services on an inpatient basis to individuals over a continuous period of 30 days or longer—

(A)(i) provides comfortable living quarters for inpatients that are clean and adequately heated, cooled, and ventilated;

(ii) provides adequate staff for its inpatients;

(iii) provides nutritional food for its inpatients;

(iv) provides inpatients with opportunities for creative activity and recreation;

(v) establishes and maintains a review committee in accordance with paragraph (2); and

(vi) informs an inpatient of all decisions involving the inpatient’s health and well-being and permits the inpatient (and the review committee upon the inpatient’s request) to participate fully in such decisions;

(B) and does not—
(i) censor or harass communication between an inpatient and others by telephone, letter, or in person;

(ii) confiscate personal property of an inpatient, unless possession of such property would interfere with the provision of health care;

(iii) deny an inpatient the social and sexual life of such individual’s preference;

(iv) require that an inpatient work;

(v) pay an inpatient less than minimum wage for work performed while receiving health care services;

(vi) physically restrain an inpatient involuntarily for a period exceeding 72 hours without the facility’s review committee (described in paragraph (2)) determining, within 72 hours of its initiation and not less often than every 2 weeks during which such restraint is continued, that such restraint is required for the physical safety of the inpatient or of others; or

(vii) take punitive or discriminatory action (including transfer between or within facilities, changes in physical comforts
and diets, changes in opportunities for social interaction and communication, or restriction of full participation in recreational and creative activities) without the prior approval, and renewed approval not less often than every week thereafter, of the facility’s review committee (described in paragraph (2)).

(2) INPATIENT REPRESENTATIVES.—

(A) ELECTION.—Each health board shall provide that at least once each year the inpatients at that time of each health care facility it operates which provides (or is designed to provide) health care services on an inpatient basis to individuals over a continuous period of 30 days or longer shall elect, from among themselves and any representatives of user associations which have a demonstrated interest in the care of such inpatients, a review committee (in this paragraph referred to as the “committee”) of not less than 3 members.

(B) RECALL.—Any member of the committee may be recalled by a vote of two-thirds of the number of inpatients in the facility.
(C) Voting.—In the case of any election or recall under this paragraph any inpatient who is not able to vote for any reason shall be permitted to appoint another individual to vote as proxy.

(f) Inspections.—In order to assure that quality care is provided in health care facilities of the Service—

(1) each area health board shall conduct regular inspections of health care facilities it has established,

(2) each regional board shall conduct regular inspections of district and community health care facilities established in its region, and

(3) the National Health Board shall conduct regular inspections of area and national health care facilities,

and the results of such inspections of a facility shall be reported to the appropriate area health board and users of the facility and shall be made available to the public.

SEC. 223. PROVISION OF HEALTH SERVICES RELATING TO REPRODUCTION AND CHILDBEARING.

(a) Provision of Services.—

(1) Family planning.—Area health boards, as appropriate, shall provide the following services:
(A) Complete information on contraception and provision of birth control materials or medication of the individual’s choosing.

(B) Complete and effective evaluation and treatment of venereal diseases and diseases of the reproductive organs.

(C) Complete information and counseling with respect to pregnancy, childbearing, and possible outcomes involving genetically induced anomalies.

(2) PREGNANCY.—Area health boards, as appropriate, shall provide the following services:

(A) Complete and effective pregnancy testing.

(B) Prenatal services, including physical examination, counseling, and instruction of expectant parents in nutrition, childrearing, and children’s health care services.

(C) Safe, comfortable, and convenient abortion services.

(D) Counseling for women in conjunction with the provision of all gynecologic, female contraceptive, and abortion services and counseling for men on male fertility-related services.
(3) **Voluntary.**—The services described in paragraphs (1) and (2) shall be delivered without coercion or harassment, with complete confidentiality, and without prior approval of individuals other than the individual receiving the services.

(4) **Accompaniment.**—An individual shall be permitted to be accompanied by a person of the individual’s choice during the provision of the services described in paragraphs (1) and (2) to the extent this would not significantly increase the medical risk to the individual.

(b) **Voluntary Consent.**—No area health board may perform upon an individual a treatment or procedure (other than a treatment or procedure required to preserve the life of the individual) which could reasonably be expected to affect the individual’s capacity to reproduce children, unless—

(1) the individual has given voluntary written consent to the treatment or procedure after being given complete information on the effect of the treatment or procedure on the individual’s reproductive capacity, and on possible alternative treatments and procedures, at least 30 days before beginning the treatment or procedure, and
(2) the individual has, after such 30-day wait-
ing period, again given written consent to the per-
formance of the treatment or procedure, except that
in the case of a woman who has given initial written
consent to a sterilization she may be sterilized in
less than 30 days following such consent (but in no
case in less than 72 hours)—

(A) if she had given initial written consent
at least 30 days before her anticipated delivery
date, she delivers before the anticipated date,
and the sterilization is performed at the time of
delivery;

(B) if she undergoes emergency abdominal
surgery within the 30-day waiting period and
the sterilization is concurrent with the abdom-
inal surgery; or

(C) in the case of an elective sterilization
procedure, such as tubal ligation or vasectomy,
that is scheduled and performed separately
from the act of childbirth, where prior informed
consent is provided and the procedure is per-
formed at the next subsequent or any later
medical visit after informed consent is obtained.

(c) Breast Cancer Treatment.—An area health
board shall insure that, before a mastectomy or other
breast cancer treatment is performed on a woman, the
woman shall be provided with complete information on the
complete range of medical options available for treatment
of her condition and the risks and side effects of each op-
tion and an opportunity to consult individuals of her
choice, and shall have given voluntary written consent to
such procedure.

(d) BIRTHING OPTIONS.—An area health board shall
provide that a woman giving birth to an infant shall have
the right to choose from a complete range of childbirth
options including—

(1) giving birth at home, in a birth center (if
available), or in a hospital;

(2) the presence during childbirth of a person
or persons of her choosing;

(3) the position for labor and delivery which she
chooses;

(4) caring for her infant at her bedside;

(5) feeding her infant according to the method
and schedule of her choice; and

(6) selecting the birth attendant of her own
choice.

She shall be provided with information on the benefits,
risks, and side effects of each option and an opportunity
to consult individuals and groups of her choosing for information and assistance on these options.

### TITLE III—HEALTH LABOR FORCE

### Subtitle A—Job Categories and Certification

#### SEC. 301. EFFECT OF STATE LAW.
Notwithstanding any law of a State or political subdivision to the contrary, the Service, acting in accordance with the provisions of this Act, shall be the sole judge of the qualifications of its employees.

#### SEC. 302. QUALIFICATIONS OF HEALTH WORKERS.

(a) Certification of Competence.—Each area health board shall, taking into account guidelines established by the National Health Board, establish procedures which will ensure that, except in emergency situations, any work which is classified under a job category established under this subtitle is performed by a health worker who at the time of such work was—

(1) certified (in accordance with this subtitle) as competent to perform the work under such job category, and

(2) authorized to perform such work by the area health board which employs such worker.
(b) Periodic Assessments.—Each area health board that employs health workers who perform work classified under a job category established under this subtitle shall provide for the periodic review and assessment of the competency of such workers to perform the work within such job category, and shall provide opportunities for health workers to be assessed and certified with respect to skills required for advancement to other job categories.

(e) Other Periodic Reviews.—In order to assure that health workers provide high quality health care services in the Service—

(1) each regional board shall provide for periodic review and assessment of the performance of health workers employed by district and community boards in its region, and

(2) the National Health Board shall provide for periodic review and assessment of the performance of health workers employed by regional boards and the National Health Board, and the results of such examinations of health workers shall be reported to the appropriate area health board and the users residing in the areas in which the health workers are employed and shall be made available to the public.
SEC. 303. ESTABLISHMENT OF JOB CATEGORIES AND CERTIFICATION STANDARDS.

(a) IN GENERAL.—

(1) CLASSIFICATION.—The National Health Board shall establish such guidelines for the classification, certification, and employment of health workers by job category as it determines to be necessary—

(A) to ensure that health workers who perform work for the Service which requires specialized skills have demonstrated that they possess such skills,

(B) to expand the roles of health workers to enable them to participate in health care delivery to the maximum extent consistent with their skills, and

(C) to provide for affiliation of health workers with health care facilities at the community, district, and regional levels.

These guidelines shall permit alternative approaches to healing, and practitioners skilled in such approaches, when these approaches have not been demonstrated to be injurious to health.

(2) CONSIDERATIONS.—In establishing guidelines under paragraph (1), the National Health Board shall provide for (A) sufficient flexibility to
permit regional health boards to utilize health workers most effectively to meet the health needs of the region, and (B) sufficient uniformity to permit mobility of health workers among the regions.

(3) Local Employment.—In establishing guidelines under paragraph (1)(C), and as appropriate to the job responsibilities of the respective health workers, the National Health Board shall require that each health worker employed by a community board must work part of the time in a health care facility operated by the respective district or regional board, and that each health worker (including the faculty of health team schools) employed by a district or regional board must work part of the time in a health care facility operated by a community board within the district or region.

(4) Periodic Evaluation.—The National Health Board shall periodically evaluate the job categories and certification practices established by area health boards under this section and shall make such modifications to its guidelines as it determines will promote the delivery of quality health care services.

(5) National Board Assistance.—The National Health Board shall assist regional boards in
applying the guidelines established under this subsection.

(b) Certification Standards.—

(1) Establishment.—For each job category (other than a job category determined by the National Health Board to involve highly specialized skills requiring advanced specialty training), each regional health board shall, taking into account the guidelines established under subsection (a), establish certification standards which shall specify—

(A) the functions performed by a healthworker employed in such job category;

(B) the skills required in the course of properly performing work under such job category;

(C) the initial and continuing training, experience, and performance which must be undertaken or demonstrated by a health worker to achieve and maintain competency to perform the work within such job category; and

(D) the curriculum which a health worker must follow in studies in a health team school (established under subtitle B) to demonstrate sufficient competence to satisfy the specification of subparagraph (C) for such job category.
Each area health board within the region shall apply such standards to all health workers employed by it. In applying such standards, such boards shall recognize health worker training, experience, and performance undertaken or demonstrated before the establishment of health team schools under subtitle B, subject to such periodic review and assessment and to such continuing training, experience, or performance as may be required under this subtitle.

(2) SPECIFICATIONS.—For each job category established and determined by the National Health Board to involve highly specialized skills requiring advanced specialty training, the National Health Board shall make the specifications described in subparagraphs (A) through (D) of paragraph (1), and area health boards shall apply such certification standards to all health workers employed by them in such job categories.

(3) PERIODIC REVIEW.—A health board which establishes standards for a job category under this subsection shall periodically review such standards and shall supplement, modify, or eliminate such standards as it determines will facilitate the delivery of quality health care services under this Act.

(4) QUALITY PROTECTION.—
(A) **Prohibition of downgrades of levels.**—No individual health facility administrator is authorized to downgrade the level of skill, license or certification required to perform duties delineated by the Board.

(B) **Review.**—

(i) **Review of staffing changes.**—
Upon enactment of this Act, the Board shall convene a national level task force to review the impact on the safety and health of patients and workers of downgrading and deskilling of health care job categories by replacing licensed with unlicensed workers during the 1990s, particularly in the nursing area, and to recommend remedies as appropriate.

(ii) **Whistleblower protection.**—
Health care workers who report compromises in the quality of care shall not be subjected to reeriminations.

(C) **Workforce staffing levels.**—The Board may establish health workforce staffing levels, or delegate that power to regional or district health boards, as it determines will promote the delivery of quality health care services.
Subtitle B—Education of Health Workers

SEC. 311. HEALTH TEAM SCHOOLS.

(a) Establishment.—

(1) In general.—Except as provided in paragraph (2), each regional board, in consultation with the community and district boards in its region, shall establish a health team school (hereinafter in this subtitle referred to as a “school”) in accordance with this section to provide programs of initial and continuing basic education in health care delivery for health workers in all job categories, and to provide initial continuing advanced education in health care specialties and health science specialty fields. Each school shall be established and functioning not later than 4 years after the effective date of health services unless the National Health Board approves a plan, submitted by the regional board, for the establishment of a school within a reasonable time after such deadline.

(2) Substitution of collaboration.—If a regional board determines, after consultation with the community and district boards in its region, that conducting particular educational programs within a school in its region would be inefficient or otherwise
inappropriate, it may collaborate with one or more regional boards for adjacent regions conducting joint educational programs. In the case of the establishment of such a joint program, all further references in this subtitle to a region or a regional board with respect to a school offering a joint program shall refer to the regions included within, and the regional boards offering, the joint program.

(3) USE OF FUNDS.—Schools shall be funded exclusively by the Service, shall not charge nor accept tuition or fees for enrollment, and shall provide each student with an adequate allowance for living expenses, educational supplies, and any child care expenses.

(4) NATIONAL BOARD ASSISTANCE.—The National Health Board shall assist regional boards in the establishment and maintenance of schools.

(b) OPERATIONAL PRINCIPLES.—Schools shall be operated and maintained in accordance with the following principles:

(1) The activities of each school shall be designed to meet the health needs of the region, districts, and communities which it serves.

(2) The number of students enrolled in each educational program in a school shall be based on
the regional, district, and community boards’ assessments of the needs for health workers within such region, districts, and communities.

(3) Schools shall integrate the education of health workers in the different job categories (established under subtitle A) so as to permit health workers to be educated and certified for successively higher levels of health care work.

(4) Each school’s admissions policies, curriculum policies, faculty hiring procedures, and governance plan shall be established and implemented by the regional board in accordance with subsections (c) through (f), respectively, and with the fullest possible participation of the community and district boards, health workers, staff, and students in its region.

(5) A school may not use individuals who are from low-income populations or minority groups, or who are women or confined in mental or penal institutions, as subjects for training or demonstration in numbers that are disproportionate to their numbers in the population of the region, and may not use any individuals as subjects for training or demonstration in a manner beyond that required for the immediate
purpose of the training or demonstration or without their explicit consent.

The National Board shall establish, not later than one year after the effective date of health services, guidelines for the application of these principles and for the phased integration of health worker education programs, including medical, dental, osteopathic, and nursing school programs, in existence on the date of enactment of this Act into the schools established under this section.

(c) ADMISSIONS POLICIES.—Each regional board shall establish and implement admissions policies for education programs in its school. Such policies shall—

(1) emphasize previous health-related work experience, as evaluated by health workers (including peers), by individuals who have received health care services from the applicant, and by faculty members;

(2) minimize the use of criteria of academic performance other than such criteria as have been shown to be significantly related to future work performance;

(3) give preference to segments of the population of the region under-represented among health workers;

(4) to the extent consistent with paragraph (3), provide for admission of individuals so that the stu-
dent body approximates the population of the region by race, sex, family income, and language; and

(5) require that the applicant agree, if accepted into the school, to perform health care services in accordance with section 312.

(d) CURRICULUM POLICIES.—Each regional board shall establish and implement curriculum policies for educational programs in its school. Such policies shall—

(1) give priority in study and field work to the leading causes of illness and death in the region, including environmental, biological, and social determinants of mortality and morbidity;

(2) give special consideration to studying the social, as well as biological, causation and prevention of illness and disease, and to the differing health care needs of populations facing special health risks and having special cultures and lifestyles within the region;

(3) provide that all students shall take a common, initial sequence of courses and that students preparing for more advanced types of health work shall take studies that are progressively more specialized and differentiated;

(4) emphasize work-study experience in all types of health care facilities in the region, including
community and workplace facilities, facilities for the
aged, mentally ill, and mentally retarded, health care
facilities in prisons and other correctional institu-
tions, alcohol and drug rehabilitation facilities, envi-
ronmental health facilities, and all other health care
facilities of the Service in communities and districts
in the region;

(5) emphasize the appropriate and safe use,
and discourage the overuse, of drugs and medical
techniques; and

(6) facilitate the development by all health
workers of skills in decisionmaking and assessment
of user needs in cooperation with other health work-
ners and with users.

e) Faculty Hiring Procedures.—Each regional
board shall establish and implement faculty hiring proce-
dures for its school. Such procedures shall, to the max-
imum extent feasible, create a faculty which approximates
the population of the region by race, sex, and language.

(f) Governance Plans.—Each regional board shall
establish and implement a governance plan for the man-
agement of its school. Such plan shall give significant deci-
sionmaking powers to staff and students of the school.

SEC. 312. SERVICE REQUIREMENT.

(a) Service Requirement.—
(1) IN GENERAL.—No individual may be enrolled by a regional board in a school unless the individual agrees to perform health care services as an employee of the Service in the job category for which training is being provided—

(A) for a period of time equal to the period of such enrollment in the school but not less than 2 years;

(B) beginning not later than 1 year after the date of the individual’s graduation from the school; and

(C) for an area health board with the highest priority ranking under subsection (c) that agrees to employ the individual.

(2) DEFERRAL.—An individual’s obligation to perform service under an agreement described in paragraph (1) shall be deferred only for a period during which the individual is physically or mentally incapable of performing such service.

(3) COMPLETION OF SERVICE REQUIRED.—No health board may employ an individual who has made an agreement described in paragraph (1), other than in accordance with subsection (c), until the individual has completed the period of obligated service in accordance with this section.
(4) Penalty for breach of agreement.—

Except as provided in paragraph (5), if an individual breaches an agreement under paragraph (1) by failing (for any reason) either to begin such individual's service obligation or to complete such service obligation, the Service shall be entitled to recover from the individual an amount determined in accordance with the formula

\[
A = \phi \left(1 - \frac{s}{t}\right)
\]

in which “\(A\)” is the amount the Service is entitled to recover; “\(\phi\)” is an amount determined by the National Health Board to be the costs to the Service of the education program and allowance received by the individual and the interest on such costs which would be payable if at the time the costs were undertaken they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States; “\(t\)” is the total number of months in the individual's period of obligated service; and “\(s\)” is the number of months of such period served by the individual. Any amount of damages which the Service is entitled to recover under this paragraph shall, within the 1-year period
beginning on the date of the breach of the agree-
ment, be paid to the Service.

(5) CANCELLATION.—

(A) UPON DEATH.—Any obligation of an
individual under this subsection for service or
payment of damages shall be canceled upon the
death of the individual.

(B) EXTREME HARDSHIP EXCEPTION.—
The National Health Board shall provide for
the waiver or suspension of any obligation of
service or payment by an individual under this
subtitle whenever compliance by the individual
is impossible or would involve extreme hardship
to the individual and if enforcement of such ob-
ligation with respect to any individual would be
unconscionable.

(C) LIMITATION ON DISCHARGE IN BANK-
RUPTCY.—Any obligation of an individual under
this subtitle for payment of damages may be re-
leased by a discharge in bankruptcy under title
11 of the United States Code only if such dis-
charge is granted after the expiration of the 5-
year period beginning on the first date that
payment of such damages is required.
(b) Periodic Reassessment of Worker Ratios.—Each area health board shall periodically assess the ratio of the number of health workers employed by the board in each job category (established under subtitle A) to the number of residents in the area.

(c) Priority Ranking.—

(1) In general.—With respect to an individual obligated to perform service under this section as a result of completion of an educational program for a job category in a school, the priority ranking (referred to in subsection (a)(1)(C)) of area health boards for hiring the individual is as follows:

(A) The regional board for the region, or a district or community board for a district or community in the region, in which the program was completed, if the region, district, or community is a health worker shortage area (as defined in paragraph (2)) with respect to the job category for which the individual received training.

(B) A regional, district, or community board (other than one described in subparagraph (A)) for a region, district, or community which is a health worker shortage area with re-
spect to the job category for which the individual received training.

(C) Any other area health board.

(2) Health worker shortage area defined.—For the purposes of paragraph (1), the term “health worker shortage area” means, with respect to a job category for which an individual has received training in a school, a region, district, or community which—

(A) has a ratio of the number of health workers in the job category employed by the regional, district or community board, respectively, to the number of residents in the region, district, or community (whichever is applicable) which is less than two-thirds of the ratio of the total number of health workers in the job category employed by all the regional, district, or community boards, respectively, in the Nation to the number of residents in the Nation, and

(B) has plans and a budget which provide for the hiring of an individual in the job category.

(3) Worker matches.—The National Health Board shall establish a program to match the locational preferences of graduates of schools with the
needs and preferences of regional, district, and community boards.

SEC. 313. PAYMENT FOR CERTAIN EDUCATIONAL LOANS.

(a) LOAN PAYMENT PROGRAM.—In the case of any individual who has incurred any educational loan before the fourth year after the effective date of health services and for the individual’s costs for an educational program in health care delivery, health care specialties, or health science specialty fields, the National Health Board shall make payments, in accordance with subsection (b), for and on behalf of that individual, on the principal of and interest on any such loan which is outstanding on the date the individual begins to work for the Service.

(b) MAKING OF PAYMENT.—The payments described in subsection (a) shall be made by the National Health Board as follows:

(1) Upon completion by the individual for whom the payments are to be made of the first year of employment with the Service, the National Health Board shall pay 30 percent of the principal of, and the interest on, each loan described in subsection (a) which is outstanding on the date he began such employment.

(2) Upon completion by that individual of the second year of such employment, the National
Health Board shall pay another 30 percent of the principal of, and the interest on, each such loan.

(3) Upon completion by that individual of a third year of such employment, the National Health Board shall pay another 25 percent of the principal of, and the interest on, each such loan.

(4) Upon completion by that individual of a fourth year of such employment, the National Health Board shall pay the remaining 15 percent of the principal of, and all remaining interest on, each such loan.

No payment may be made under this subsection with respect to a loan unless the person on whose behalf the payment is to be made has submitted to the National Health Board a certified copy of the agreement under which such loan was made.

(c) Payment During Employment.—Notwithstanding the requirement of completion of employment specified in subsection (b), the National Health Board shall on or before the due date thereof, pay any loan or loan installment which may fall due within the period of employment for which the borrower may receive payments under this section, upon the declaration of such borrower, at such times and in such manner as the National Health Board may prescribe (and supported by such other evi-
dence as the National Health Board may reasonably re-
quire), that the borrower is then employed as described
in subsection (b) and that the borrower will continue to
be so engaged for the period required (in the absence of
this subsection) to entitle the borrower to have made the
payments provided by this section for such period, except
that not more than 85 percent of the principal of any such
loan shall be paid pursuant to this subsection.

Subtitle C—Employment and Labor-Management Relations
Within the Service

SEC. 321. EMPLOYMENT, TRANSFER, PROMOTION, AND RE-
CEIPT OF FEES.

(a) Service Employees.—Health boards shall, in
accordance with this Act and taking into account guide-
lines and standards established by the appropriate Na-
tional Health Board, employ, classify, and fix the salaries
and benefits of all employees of the Service employed in
the Service’s facilities.

(b) Policies.—The appropriate National Health
Board, in establishing guidelines and standards under this
subtitle, shall, to the extent feasible and consistent with
the provisions of this subtitle, provide for—
(1) employment and promotion in the Service in the same manner as is provided for employment and promotion under the Federal civil service system;

(2) meaningful opportunities for career advancement;

(3) encouragement of health workers to use up to 10 percent of their work time for continuing education under subtitle B without loss of pay or other job rights; and

(4) full protection of employees’ rights by providing an opportunity for a fair hearing on adverse actions with representation of their own choosing.

(c) HIRING PREFERENCES.—Health boards, in hiring employees to fill vacancies in newly created positions, shall give preference to individuals who were employed as health workers, or self-employed while delivering health services, before the date of enactment of this Act. The National Health Board shall ensure, through such steps as it deems necessary, that all such individuals desiring to be employed within the Service shall find appropriate employment in the Service.

(d) PROMOTION AND TRANSFER.—Employees of the Service shall be eligible for promotion or transfer to any position in the Service for which they are qualified. Each regional board shall establish and maintain a job place-
ment service to assist health workers in its region in ident-
ifying suitable employment opportunities and in transfer-
ring between jobs with different area health boards in the
region. The authority given by this subsection shall be
used to provide a maximum degree of career opportunities
for employees and to ensure continued improvement of
health care services.

(e) Vacancies.—A community or district board may
not hire an individual to fill a job vacancy that is classified
under subtitle A in a job category if—

(1) the community or district board, respec-
tively, has a ratio of the number of health workers
in the job category employed by such board to the
number of residents in the community or district
(whichever is applicable) which is greater than four-
thirds of the ratio of the total number of health
workers in the job category employed by all the com-
munity or district boards, respectively, in its region
to the number of residents in such region; and

(2) there is a community or district within its
region which is a health worker shortage area (as
defined in section 312(c)(2)) with respect to the job
category.

(f) No Undue Financial Incentives.—No health
worker should benefit financially from the provision or de-
nial of services to individual patients, beyond their regular
remuneration.

(g) SOLE EMPLOYER.—An employee of the Service
may not receive any fee or perquisite on account of duties
performed by virtue of such employment, except from a
health board established under this Act.

(h) GRANDFATHER CLAUSE.—The National Board
shall support alternative procedures to assure that health
care professionals meet required standards, particularly
those currently practicing in health professional shortage
areas in inner cities and in rural communities.

(i) TRANSITIONAL EMPLOYMENT.—Up to 1 percent
of the budget of the United States Health Service for each
of its first 2 years may be expended for the retraining
and hiring of sales, administrative, clerical, and service
employees displaced as a result of this Act, including those
in the health insurance industry.

SEC. 322. APPLICABILITY OF LAWS RELATING TO FEDERAL
EMPLOYEES.

(a) IN GENERAL.—Chapter 75 of title 5, United
States Code (relating to adverse actions against employ-
ees), apply to employees of the Service (other than employ-
ees serving on the personal staff of members of health
boards) except to the extent provided—
(1) in a collective-bargaining agreement negotiated on behalf of and applicable to them; or

(2) in procedures established by the Service and approved by the Office of Personnel Management.

(b) COVERAGE UNDER WORKERS COMPENSATION.—

Employees of the Service are covered by subchapter I of chapter 81 of title 5, United States Code (relating to compensation for work injuries).

(c) CIVIL SERVICE.—

(1) APPLICATION OF CIVIL SERVICE RETIREMENT.—Chapter 83 of title 5, United States Code (relating to civil service retirement), applies to employees of the Service except to the extent provided in a collective-bargaining agreement negotiated on behalf of and applicable to them.

(2) WITHHOLDING.—The Service shall withhold from pay and shall pay into the Civil Service Retirement and Disability Fund the amounts specified in chapter 83 of title 5, United States Code, as required under paragraph (1). The Service, upon request of the Office of Personnel Management, but not less frequently than annually, shall pay to the Office the costs reasonably related to the administration of Fund activities for employees of the Service.
(d) ACCRUAL OF SICK AND ANNUAL LEAVE.—Sick and annual leave and compensatory time of employees of the Service, whether accrued prior to or after the commencement of operations of the Service, shall be obligations of the Service.

(e) APPLICATION OF CONDITIONS.—

(1) TERMS OF EMPLOYMENT.—Compensation, benefits, and other terms and conditions of employment in effect on the effective date of health services for employees of the Federal Government performing functions that are provided under this Act by the Service, shall apply to all employees of the Service performing similar functions until changed by the Service in accordance with this Act. Subject to the provisions of this Act, the provisions of subchapter I of chapter 85 and chapter 87 of title 5, United States Code (relating to unemployment compensation and life insurance), apply to employees of the Service unless varied, added to, or substituted for in accordance with paragraph (2).

(2) LIMITATION ON VARIATION.—No variation, addition, or substitution with respect to fringe benefits shall result in a program of fringe benefits which on the whole is less favorable to employees of the Service than fringe benefits in effect for employees
of the Federal Government on the effective date of
health services. No variation, addition, or substitu-
tion with respect to fringe benefits of employees
for whom there is a collective-bargaining representa-
tive shall be made except by agreement between such
representative and the Service.

SEC. 323. APPLICABILITY OF FEDERAL LABOR-MANAGE-
MENT RELATIONS LAWS.

(a) Application of NLRA.—

(1) In general.—The provisions of the Na-
tional Labor Relations Act (42 U.S.C. 141 et seq.)
shall apply to the Service and its employees to the
extent, not inconsistent with subsection (b), to which
such provisions apply to employers (as defined in
section 2(2) of such Act), except that—

(A) the phrase “or any individual employed
as a supervisor” in section 2(3) of such Act
shall not apply (thereby making such Act apply,
for these purposes, to such individuals);

(B) section 9(b)(1) of such Act (providing
for separate treatment for professional and
nonprofessional employees) shall not apply;

(C) sections 206 through 210 of such Act
(relating to national emergencies) shall, for pur-
poses of this Act, have the phrases “the Presi-
dent of the United States” and “the Presi-
dent”, wherever they appear, replaced by the
phrase “the National Health Board (or a com-
mittee thereof to which it has delegated such
authority)” and the phrase “national health or
safety” replaced by the phrase “health or safety
of the residents of any region”; and

(D) section 213 (providing for intervention
in a strike or lockout by the Director of the
Federal Mediation and Conciliation Service)
shall not apply.

(2) STRIKES PERMITTED.—Paragraphs (3) and
(4) of section 7311 of title 5, United States Code
(prohibiting participation in a strike or an organiza-
tion asserting the right to strike), shall not apply
to employees of the Service.

(b) NEUTRALITY IN UNION MATTERS.—The Na-
tional Health Board shall adopt as a matter of general
policy that governing boards at each level of the Service,
and employers acting as agents of these boards, agree to
determine employee preference on the subject of labor
union representation, and to determine which one if union
representation is preferred, by a card check procedure con-
ducted by a neutral third party in lieu of a formal election.

(c) COLLECTIVE BARGAINING.—
(1) In general.—Collective-bargaining agreements between area health boards and duly recognized bargaining representatives of employees of the Service may include procedures for resolution by the parties of grievances and adverse actions arising under the agreement, including procedures culminating in binding third-party arbitration.

(2) Alternative procedures.—Area health boards and duly recognized bargaining representatives of employees of the Service may by mutual agreement adopt procedures for the resolution by the parties—

   (A) of grievances and adverse actions arising under collective-bargaining agreements, and
   (B) of disputes or impasses arising in the negotiation of such agreements.

(d) Conforming amendment.—Section 3(e) of the Labor-Management Reporting and Disclosure Act of 1959 (42 U.S.C. 402(e)) is amended by inserting “the United States Health Service and” after “and includes”.

SEC. 324. DEFENSE OF CERTAIN MALPRACTICE AND NEGLIGENCE SUITS.

(a) Exclusive remedy.—The remedy against the United States provided by sections 1346(b) and 2672 of title 28, United States Code, or by alternative benefits

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provided by the United States where the availability of
such benefits precludes a remedy under section 1346(b)
of such title, for damage for personal injury, including
death, resulting from the performance of medical, surgical,
dental, or related functions, including the conduct of clin-
ical studies or investigations, by any employee of the Serv-
vice while acting within the scope of the employee’s employ-
ment, shall be exclusive of any other civil action or pro-
ceeding by reason of the same subject matter against the
employee (or the employee’s estate) whose act or omission
gave rise to the claim.

(b) Defense.—The Attorney General shall defend
any civil action or proceeding brought in any court against
any person referred to in subsection (a) (or the person’s
estate) for any such damage or injury. Any such person
against whom such civil action or proceeding is brought
shall deliver within such time after date of service or
knowledge of service as determined by the Attorney Gen-
eral, all process served upon the person or an attested true
copy thereof to the person’s immediate superior or to
whomever was designated by the appropriate National
Health Board to receive such papers and such person shall
promptly furnish copies of the pleading and process there-
in to the United States attorney for the district embracing
the place wherein the proceeding is brought, to the Attor-
ney General, and to the appropriate National Health Board.

(c) Procedure.—

(1) Removal from state courts.—Upon a certification by the Attorney General that the defendant was acting in the scope of employment at the time of the incident out of which the suit arose, any such civil action or proceeding commenced in a State court shall be removed without bond at any time before trial by the Attorney General to the district court of the United States of the district and division embracing the place wherein it is pending and the proceeding deemed a tort action brought against the United States under the provision of title 28, United States Code, and all references thereto.

(2) Motions to remand.—If a United States district court determines on a hearing on a motion to remand held before a trial on the merits that the case so removed is one in which a remedy by suit within the meaning of subsection (a) is not available against the United States, the case shall be remanded to the State court.

(3) Effect of alternative remedies.—
Where a remedy by suit within the meaning of sub-
section (a) is not available because of the availability of a remedy through proceedings for compensation or other benefits from the United States as provided by any other law, the case shall be dismissed, but in the event the running of any limitation of time for commencing, or filing an application or claim in, such proceedings for compensation or other benefits shall be deemed to have been suspended during the pendency of the civil action or proceeding under this section.

(d) SETTLEMENT.—The Attorney General may compromise or settle any claim asserted in such civil action or proceeding in the manner provided in section 2677 of title 28, United States Code, and with the same effect.

(e) LIMITATION.—For purposes of this section, the provisions of section 2680(h) of title 28, United States Code, shall not apply to assault or battery arising out of negligence in the performance of medical, surgical, dental, or related functions, including the conduct of clinical studies or investigations.

(f) LIABILITY INSURANCE.—The appropriate National Health Board may, to the extent it deems appropriate, hold harmless or provide liability insurance for any employee of the Service for damage for personal injury, including death, negligently caused by such employee while
acting within the scope of employment and as a result of
the performance of medical, surgical, dental, or related
functions, including the conduct of clinical studies or in-
vestigations, if the employee is assigned to a foreign coun-
try or detailed to a State or political subdivision thereof
or to a nonprofit institution, and if the circumstances are
such as are likely to preclude the remedies of third persons
against the United States described in section 2679(b) of
title 28, United States Code, for such damage or injury.

Title IV—Other Functions
Of Health Boards
Subtitle A—Advocacy, Grievance
Procedures, and Trusteeships

Sec. 401. Advocacy and Legal Services Program.
(a) Establishment of Program.—Each area
health board shall establish a program of health advocacy
to ensure the full realization of the patient rights enumer-
ated in subtitle A of title II. Such a program shall
include—

(1) the employment of individuals having basic
legal knowledge and skills as health advocates;

(2) the presence of health advocates—

(A) in inpatient health care facilities at all
times; and
(B) in other health care facilities during
the provision of health care services;

(3) provision for health advocates to (A) in-
form, on an ongoing basis, users and health workers
of such patient rights and (B) report to the area
health board any infraction of such rights which is
not promptly corrected;

(4) provision for regular meetings between
health workers and health advocates, users, and any
user representatives to discuss ways of ensuring the
fulfillment of such rights through affirmative action
of such workers and the area health board; and

(5) appropriate action by the area health board
to ensure that infractions of such rights are prompt-
ly and sufficiently corrected.

(b) Health Rights Legal Services.—

(1) Establishment of Program.—The Na-
tional Health Board shall establish a health rights
legal services program and shall provide such pro-
gram with sufficient legal and administrative per-
sonnel, funding, and facilities (A) to ensure that
users and health workers receive, free of charge,
high quality legal services (including representation
in grievance proceedings commenced under section
402) for legal problems related to health rights and
health care services, and (B) to improve, through litigation and other activities, the health care system and expand the rights of users and health workers.

(2) SERVICES.—The health rights legal services program shall provide directly, by contract with the Legal Services Corporation, or by contract with members of the private bar, for—

(A) establishment of a legal services office in each region to provide representation (other than representation provided under subparagraph (B)) of users, health workers, and voluntary associations having a demonstrated interest in health care in proceedings and hearings under sections 324 and 402; and

(B) establishment of legal services offices in such communities and districts as are determined, in accordance with guidelines established by the National Health Board, to have inadequate legal services to provide the legal services described in paragraph (1)(A).

(3) USE OF CONTRACTS.—The National Health Board may carry out the functions described in paragraph (1)(B) directly, by contract, or otherwise.

SEC. 402. GRIEVANCE PROCEEDURES AND TRUSTEESHIPS.

(a) GRIEVANCE PROCEEDINGS.—
(1) **BEFORE REGIONAL BOARDS.**—Each regional and interim regional board shall provide, in accordance with this section, that any user, health worker, or any user association having a demonstrated interest in health care may commence a grievance proceeding before such board (or a person or committee designated by such board) with respect to an alleged violation of this Act by a district or community board within its region. Each regional and interim regional board may commence a grievance proceeding before itself (or a person or committee designated by such board) with respect to an alleged violation of this Act by a district or community board within its region.

(2) **BEFORE NATIONAL BOARD.**—The appropriate National Health Board shall provide, in accordance with this section, that any user, health worker, or any user association having a demonstrated interest in health care may commence a grievance proceeding before such Board (or a person or committee designated by such Board) with respect to an alleged violation of this Act by a regional or interim regional board. The appropriate National Health Board may commence a grievance proceeding before itself (or a person or committee designated by
such Board) with respect to an alleged violation of this Act by a regional or interim regional board.

(b) REVIEW.—

(1) BY NATIONAL BOARD.—The appropriate National Health Board shall provide, subject to paragraphs (2) and (3), for its review (or a review by a person or committee designated by the Board), by appeal to the Board by any party to a proceeding described in subsection (a)(1) or on its own initiative, of an adverse decision by a regional or interim regional board in the proceeding.

(2) LIMITATION ONCE SUIT COMMENCED.—On and after the date a suit with respect to an adverse determination in a grievance proceeding or review proceeding is filed under subsection (e), no review proceeding respecting such proceeding may be commenced by appeal to the Board under paragraph (1), and any such review proceeding which was commenced by appeal to the Board under such paragraph before the date of filing of such suit and is pending on such date shall promptly be discontinued.

(3) TIME LIMIT.—No review of an adverse administrative decision may be made by appeal or by initiative under this subsection unless the appeal is
filed or notice of the initiative is published (as the case may be) not later than 15 days after the publication of the decision.

(c) INVESTIGATION.—

(1) IN GENERAL.—Whenever a grievance proceeding is commenced under subsection (a), the entity before which the proceeding is held shall investigate the grievance.

(2) HEARING.—An entity before which a proceeding or review proceeding is commenced under subsection (a) or (b)—

(A) shall conduct a full and open public hearing on the grievance as part of such proceeding—

(i) if the grievance is supported by a petition signed by a minimal number of residents (as defined in paragraph (4)); or

(ii) before the entity (or the body which designated it) may set aside an election or transfer any functions of a health board under subsection (d); and

(B) may conduct such a hearing if the entity determines that such hearing is in the public interest.
(3) **Notice.**—The entity that conducts a hearing under paragraph (2) shall provide for timely notice to, and opportunity to be heard by, any party with a direct interest in the grievance for which the hearing is conducted.

(4) **Minimal Number of Residents Defined.**—As used in paragraph (1), the term “minimal number of residents” means, with respect to a grievance which concerns a health board which is—

(A) a community board, 100 individuals,

(B) a district board, 300 individuals, and

(C) a regional or interim regional board, 1,000 individuals,

who are 18 years of age or older and who reside in the area served by the board.

(d) **Actions Upon Grievances.**—

(1) **Election Grievances.**—With respect to a grievance proceeding begun under subsection (a) relating to the conduct of an election of a community board, if the entity before which such proceeding is commenced under such subsection, or is reviewed under subsection (b), determines that the election—

(A) was not conducted substantially in compliance with this Act, or
(B) has revealed the systematic failure of the user members of such community board to approximate the population of the community by race, sex, language, and income level, the entity shall set aside the election and, unless such determination is reviewed under subsection (b), the entity shall require that another election for members of the community board be conducted, in accordance with this Act, not later than 60 days after the date of such determination. If such election is conducted because of a determination under subparagraph (B), the election shall be conducted (and subsequent elections may be conducted) in such a manner, including the use of geographic or other subdivisions for electoral purposes, as will facilitate the representation of significant elements of the population of a community by race, sex, language, and income level.

(2) OTHER GRIEVANCES.—With respect to a grievance proceeding begun under subsection (a) relating to a grievance other than the conduct of an election of a community board, if the entity before which such proceeding is commenced under such subsection, or is reviewed under subsection (b), determines that the grievance represents—
(A) a failure by a health board to comply substantially and materially with this Act, the entity shall require that a new election or appointment, in accordance with this Act, of members of the health board be conducted or made within 60 days of the date of such determination; or

(B) a failure by a health board to comply, but not substantially and materially, with this Act, the entity may require that a new election or appointment, in accordance with this Act, of members of the health board be conducted or made if such failure is not corrected within a reasonable period of time (specified by the entity) of the date of such determination.

(3) Transfer of functions.—

(A) To regional boards.—If an entity determines under paragraph (1) or (2) that a community or district board has failed to comply with this Act, the entity shall transfer to the regional (or interim regional) board for such community or district such functions of the community or district board as it determines necessary to carry out this Act until a
new election or appointment is conducted or made.

(B) TO NATIONAL BOARD.—If an entity determines under paragraph (2) that a regional or interim regional board has failed to comply with this Act, the entity shall transfer to the appropriate National Health Board such functions of the regional or interim regional board as it determines necessary to carry out this Act until a new regional or interim regional board is appointed.

(C) TRANSITIONAL AUTHORITY.—If a health board is transferred the functions of another health board under this paragraph, until a new election or appointment of the other health board has been certified—

(i) the health board shall have the powers of the other health board to conduct such functions;

(ii) the health board may appoint a trustee (or trustee committee) to have such powers and carry out such functions; and

(iii) any expenses that are certified by the health board (or by the trustee or trustee committee appointed by it) as hav-
ing been incurred by it in discharging the
functions transferred to it under this para-
graph shall be paid from funds allocated to
the other health board.

(e) RIGHT TO SUE.—Any party to a grievance pro-
ceeding or review proceeding commenced under this sec-
tion may bring suit in the United States district court for
the judicial district in which such proceeding, or review
proceeding, was brought, for the review of an adverse de-
termination in such proceeding or review proceeding. Such
court shall affirm such determination unless it finds that
such determination is not supported by substantial evi-
dence or is arbitrary and capricious.

Subtitle B—Occupational Safety
and Health Programs

SEC. 411. FUNCTIONS OF THE NATIONAL HEALTH BOARD.

(a) OVERSIGHT AUTHORITY.—On and after the effec-
tive date of health services, the National Health Board
shall oversee occupational safety and health programs con-
ducted at the regional level, and shall participate in the
establishment and administration of occupational safety
and health standards under the Occupational Safety and
Health Act of 1970.

(b) SEEKING ADVICE.—In its participation in the es-
tablishment and administration of occupational safety and
health standards under the Occupational Safety and
Health Act of 1970, the National Health Board shall seek
the advice and comments of regional occupational safety
and health action councils established under section 413.

(e) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—To provide for participation
of the National Health Board in the establishment
and administration of occupational safety and health
standards, the Occupational Safety and Health Act
of 1970 (29 U.S.C. 651 et seq.) is amended—

(A) by adding at the end of section 3 the
following new paragraph:

“(15) The term ‘National Health Board’ means
the National Health Board of the United States
Health Services.”;

(B) by striking “Secretary of Health and
Human Services” each place it appears (other
than in section 22(b)) and inserting “National
Health Board”;

(C) by inserting “shall request the Na-
tional Health Board and” in the first sentence
of section 6(b)(1) before “may request”; 

(D) by inserting “the Board and” in the
second sentence of section 6(b)(1) after “The
Secretary shall provide”;

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(E) by striking “An” in the third sentence of section 6(b)(1) and inserting “The Board and an”; 

(F) by striking “its” each place it appears in the third sentence of section 6(b)(1) and inserting “their”; 

(G) by inserting “after consultation with the National Health Board and” in the fourth sentence of section 6(b)(6)(A) after “may be granted only”; 

(H) by inserting “after consultation with the National Health Board and” in the third sentence of section 6(d) before “after opportunity for”; 

(I) by striking “The Secretary” and all that follows through “shall each” in section 8(g)(2) and inserting “The Secretary shall”; 

(J) by striking “their” in section 8(g)(2) and inserting “his”; 

(K) by inserting “after consultation with the National Health Board and” in section 16 before “after notice and opportunity”; 

(L) by inserting “(after consultation with the National Health Board)” in section 18(c) after “in his judgment”;
(M) by inserting “and the National Health Board” in section 19(d) after “Secretary” each place it appears; and

(N) by striking the first sentence of paragraph (5) of section 20(a).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the effective date of health services.

(f) GUIDELINES.—The National Health Board shall establish guidelines—

(1) for its participation in the establishment and administration of occupational safety and health standards under the Occupational Safety and Health Act of 1970;

(2) for the election of community occupational safety and health action councils under section 412;

(3) for the establishment of regional occupational safety and health programs under section 413;

(4) for the establishment and operation of workplace health facilities under section 414; and

(5) for the provision of assistance by regional and community boards to regional and community occupational safety and health councils, respectively, and to workplace safety and health committees established under section 415.
SEC. 412. COMMUNITY OCCUPATIONAL SAFETY AND
HEALTH ACTIVITIES.

(a) DESCRIPTION OF ACTIVITIES.—

(1) COOPERATION WITH REGIONAL BOARD.—
Each community board shall cooperate with the ap-
propriate regional board in the establishment and
implementation of an occupational safety and health
program for its region.

(2) ESTABLISHMENT OF COMMUNITY OCCUPA-
TIONAL SAFETY AND HEALTH ACTION COUNCIL
(COSHAC).—Each community board shall provide for
the organization and operation (including staff and
support) in its community of a community occupa-
tional safety and health action council (hereinafter
in this subtitle referred to as a “COSHAC”’) in ac-
cordance with this section.

(b) MEMBERS OF COSHAC.—The members of a
COSHAC shall be elected by individuals employed in the
community as follows:

(1) Employees of each workplace in the commu-
nity which has 500 or more employees shall be enti-
tled to elect one member for each 500 such employ-
ees in such workplace.

(2) Employees of workplaces in the community
which have fewer than 500 employees shall be enti-
tled to vote in community-wide elections for a num-
ber of members equal to (A) the total number of employees in such workplaces divided by 500, (B) rounded (if necessary) to the next highest whole number.

The elections of COSHAC members shall be conducted by the community board for such COSHAC under guidelines established by the National Board.

(c) DUTIES OF COSHAC.—Each COSHAC shall—

(1) appoint one individual to serve, at its pleasure, as a member of the community board for such COSHAC;

(2) appoint one individual to serve, at its pleasure, as a member of the regional occupational safety and health action council for its region;

(3) advise the community board on, and oversee, occupational safety and health programs in the community;

(4) promote and assist in the establishment of workplace occupational safety and health committees in workplaces in the community, and advise and facilitate such committees’ actions relating to safety and health hazards in workplaces in the community; and
(5) assist employees in determining methods of, and requirements for, inspections of workplaces in the community for safety and health hazards.

SEC. 413. REGIONAL OCCUPATIONAL SAFETY AND HEALTH PROGRAMS.

(a) Regional Programs.—

(1) Establishment.—Each regional board shall establish an occupational health and safety program for its region in accordance with this subsection and under guidelines established by the National Health Board.

(2) Use of Community Facilities.—A regional occupational health and safety program shall, to the maximum extent feasible, use the facilities and resources of community boards in the region and shall include—

(A) training programs to enhance the ability of employees in the region to monitor safety and health conditions in their workplaces and to assist safety and health inspectors in the conduct of workplace inspections;  
(B) facilitating communication among workers employed in similar industries in the region and the Nation with respect to occupa-
tional health and safety hazards they face in common;

(C) baseline and periodic biologic screening of employees in the region;

(D) development and maintenance of environmental monitoring programs to identify and isolate hazardous workplaces and work areas in the region;

(E) the analysis of employment-related injuries and illnesses occurring in the region; and

(F) staff and support for the operation of the regional occupational safety and health action council (hereinafter in this subtitle referred to as the “ROSHAC”) established in the region under this section.

(b) DUTIES OF REGIONAL OCCUPATIONAL SAFETY AND HEALTH ACTION COUNCILS (ROSHACs).—Each ROSHAC shall—

(1) appoint one individual to serve, at its pleasure, as a member of the regional board for such ROSHAC;

(2) advise the regional board on, and oversee, occupational safety and health programs in the region; and
(3) advise the National Health Board on the establishment and administration of occupational safety and health standards under the Occupational Safety and Health Act of 1970.

SEC. 414. WORKPLACE HEALTH FACILITIES.

(a) Establishment.—Each Community Health Board shall establish worksite health facilities, distributed to make available occupational and emergency health care services to individuals employed in the workplace in accordance with this section and guidelines and standards for such facilities established by the National Health Board. Such facilities shall be maintained by each employer where the facility is located, or by the group of employers covered by a facility if the Community Health Board determines that a shared site is optimal.

(b) Application of Guidelines.—Each workplace health facility established pursuant to subsection (a) shall, taking into account guidelines established by the National Health Board—

(1) be organized in a manner so as to provide an appropriate number of appropriately skilled health workers to meet occupational and emergency health care needs of employees in the workplace; and

(2) be operated by the community board for the community in which the workplace is predominantly
located, or, where such board deems appropriate, by
the employer, with the cost in either case borne by
the employer in each workplace.

SEC. 415. EMPLOYEE RIGHTS RELATING TO OCCUPATIONAL
SAFETY AND HEALTH.

(a) WORKPLACE COMMITTEES.—

(1) Establishment.—Employees in each
workplace having 25 or more employees shall have
the right to establish workplace occupational safety
and health committees (hereinafter in this sub-
section referred to as “committees”) with members
of their choosing.

(2) Membership.—Members of committees
(composed of the greater of 3 members or one mem-
ber for each 100 employees in the workplace) shall,
without any loss of pay or other job rights—

(A) be permitted to spend eight hours of
each month inspecting their workplace and con-
ducting such other functions relating to occupa-
tional safety and health as are determined by
the employees in the workplace; and

(B) be permitted to accompany any safety
and health inspectors during inspections of the
workplace.
(b) SAFETY-RELATED RIGHTS.—Employees in each workplace shall have the right, without any loss of pay or other job rights—

(1) to monitor safety and health conditions in their workplace whenever they reasonably deem it necessary and with whatever reasonable scientific instruments and expert assistance they choose; and

(2) to remove themselves from the site of any hazard to their safety or health until an authorized inspector has certified that the hazard has been eliminated.

(c) SAFE WORKPLACES.—Employers shall adopt all feasible engineering measures that will minimize occupational safety and health hazards in the workplace. Where such measures are not adequate to protect employees from such hazards, employers shall furnish their employees with, or reimburse their employees for the reasonable cost of, equipment and clothing needed to protect an employee from any residual occupational safety and health hazards in the workplace.

(d) RIGHT TO INSPECT MEDICAL RECORDS.—Employees or their duly chosen representatives shall have the right to inspect all medical records maintained by their employers on the condition of their health, and shall have
the right to be assisted during such inspections by persons of their choosing.

(e) **Copies of Reports.**—Employers shall provide their employees with copies of all reports, studies, and data concerning conditions affecting the health and safety of employees within their workplaces, with annual reports on the morbidity and mortality experience of present and former employees, and with timely notification of the presence within the workplace of any materials, agents, or conditions which may have a deleterious effect on the safety and health of their employees, along with relevant information on hazards and precautions, symptoms, remedies, and antidotes.

(f) **Right To Negotiate Standards.**—Employees shall have the right to seek, through collective bargaining, occupational safety and health standards, including standards relating to physical and mental stress and speed of work, more restrictive than such standards established under the Occupational Safety and Health Act of 1970.

**SEC. 416. DEFINITIONS.**

(a) **Workplace.**—For purposes of this subtitle, the term “workplace” means the regular location where work is performed by one or more employees of an employer.

(b) **Employer; Employee.**—For the purposes of sections 414 and 415, the terms “employer” and “em-
ployee” have the same meanings those terms have in section 3 of the Occupational Safety and Health Act of 1970 (42 U.S.C. 653).

Subtitle C—Health and Health Care Delivery Research, Quality Assurance, and Health Equity

SEC. 421. PRINCIPLES AND GUIDELINES FOR RESEARCH.

(a) Conduct.—On and after the effective date of health services, the Service shall conduct a program of research concerning health and health care delivery. On and after 2 years after such date, such research program shall conform to the following principles:

(1) The research shall, to the maximum extent possible, be performed under the direction of, and in association with, community, district, and regional boards.

(2) No research shall be conducted within, or using the resources of, an area health facility until it has been reviewed and approved by the area health board responsible for such facility.

(3) Priority shall be given in health research to the prevention and correction of the leading causes of illness and death, particularly environmental, occupational, nutritional, social, and economic causes.
(4) Priority shall be given in health care delivery research to improvement of the effectiveness and efficiency of ambulatory and primary health care delivery, including research on alternative systems of health care delivery and alternative conceptions of health and health care.

(5) The National Health Board shall encourage and support the conduct of clinical trials that may improve the health of the public. Any clinical trial conducted with the intention of evaluating new preventive, diagnostic, or therapeutic methods or agents shall be conducted only in accordance with established ethical procedures that protect subjects from undue harm. If benefit becomes apparent, by scientific consensus, before the scheduled conclusion of any clinical trial, such trial shall nevertheless be terminated, and the benefit made available to trial participants and the public at large.

(6) No research shall be conducted on a human subject without the subject’s informed written consent.

(7) No research shall be conducted on a human subject while the subject is involuntarily confined to an institution.
(8) Each health board, in planning and conducting research under the program, shall cooperate with appropriate officials conducting related research in the Federal Government and agencies and departments of State, territorial, and local governments.

(9) The results of research shall be disseminated to the public and to area health boards in a manner that will most readily permit the use of such results to improve the health of users and the delivery of health care services.

(b) GUIDELINES.—The National Health Board shall establish guidelines for the conduct of research in conformance with the principles described in subsection (a).

SEC. 422. ESTABLISHMENT OF INSTITUTES.

On the effective date of health services, the National Institutes of Health (established under title IV of the Public Health Service Act) are transferred to the National Health Board. In addition, the National Health Board shall establish the following institutes:

(1) NATIONAL INSTITUTE OF EPIDEMIOLOGY.—A National Institute of Epidemiology, which shall—

(A) gather and analyze disease-related statistics collected by the Service;
(B) plan, conduct, support, and assist in epidemiologic research conducted by the Service;

(C) conduct and support research on epidemiologic methodology and experimental epidemiology;

(D) establish and maintain an early warning system for the detection of new diseases and epidemics; and

(E) assist in the formulation of policies to eliminate or reduce the causes of illness and injury and to prevent and curtail epidemics of these conditions.

(2) NATIONAL INSTITUTE OF EVALUATIVE CLINICAL RESEARCH.—A National Institute of Evaluative Clinical Research, which shall—

(A) create a uniform electronic data base for research on quality improvement in clinical care and the organization and delivery of services, and for research on outcomes of care;

(B) assess and analyze evidence on newly-discovered or proposed preventive, diagnostic, and therapeutic methods and agents, including new technologies, and assist the National Health Board, in cooperation with other bodies,
including the National Institute of Pharmacy
and Medical Supply, in developing guidelines
and standards for their introduction;

(C) analyze evidence on newly-discovered
or proposed preventive, diagnostic, and therapeu
tic methods and agents;

(D) plan and conduct clinical trials, in con-
formance with the limitations of subtitle A of
title II;

(E) assist the National Health Board, in
cooperation with other bodies, including the Na-
tional Institute of Pharmacy and Medical Sup-
ply, in developing guidelines and standards for
the introduction of new methods of prevention,
diagnosis, and treatment;

(F)(i) regularly assess and recommend
measures to improve the health status of the
population, which methods shall include anal-
ysis of the national health data base, regular
surveys of the population regarding their expe-
rience and evaluation of their health and health
services, and such other methods as designated
by the Institute;

(ii) identify the most effective methods of
prevention, diagnosis and treatment, as deter-
mined by the most recent evidence, and assist
the National Health Board, in cooperation with
other bodies, in establishing guidelines to im-
prove clinical practice, including clinical deci-
sion criteria per section 221(f);

(iii): regularly monitor and report to the
National Health Board for further action the
extent of inappropriate care, including under-
service and overservice, and its consequences;

(iv) develop additional methods of quality
improvement for implementation by the Na-
tional Health Board and other entities, includ-
ing systematic review of patterns of practice
that compromise the quality of care and rec-
ommendations to redress such practices, edu-
cation for health care workers to improve the
quality of care, and guidelines for the optimal
organization of health services and the use of
tertiary care facilities;

(G) administer the periodic convening of
the U.S. Preventive Health Services Task
Force, which shall recommend to the National
Board a schedule for preventive health services
based on age and sex, which schedule shall re-
fect the most recent medical evidence; and
(H) provide education for users on clinical
effectiveness guidelines and the most effective
preventive, diagnostic, and treatment practices.

(3) **National Institute of Health Care**

**Services.**—A National Institute of Health Care

Services, which shall—

(A) analyze data and statistics on the
health care resources and needs of the Nation
and on the quality of present services;

(B) conduct comparative studies of health
care services in the various regions of the Na-
tion, and make recommendations for the im-
provement of health care services in areas with
inferior quality of health care services;

(C) plan and conduct research on alter-
native methods of health care delivery, on the
functions, tasks, performance and work rela-
tionships of various kinds and categories of
health workers, on patterns of organization of
health care, and on the effectiveness and bene-
fits of health care in relation to costs; and

(D) assist the National Health Board in
formulating national policies to improve the
quality of health care services.
(4) NATIONAL INSTITUTE OF PHARMACY AND MEDICAL SUPPLY.—A National Institute of Pharmacy and Medical Supply, which shall—

(A) recommend to the National Health Board standards regarding the quality, distribution, and price of all drugs, therapeutic devices, appliances and equipment to be used by the Service;

(B) certify drugs, therapeutic devices, appliances, and equipment for use in the health facilities of the Service, and for furnishing to users of such health facilities;

(C) assist the National Health Board in issuing a National Pharmacy and Medical Supply Formulary; and

(D) conduct a comprehensive program of pharmaceutical and medical supply research and utilization education using, to the maximum extent possible, regional facilities operated in association with the respective regional health boards.

(5) NATIONAL INSTITUTE OF SOCIOLOGY OF HEALTH AND HEALTH CARE.—A National Institute of Sociology of Health and Health Care, which shall—
(A) conduct ongoing analyses of the basic epistemological assumptions of health and health care;
(B) assess critically the effects of scientific medicine and of divisions in institutional and technical skills in health care;
(C) evaluate the effects of health care measures and policies upon population groups and subgroups in the Nation;
(D) identify and analyze the social, economic, occupational, distributional, and environmental factors in modern society affecting health and well-being;
(E) analyze alternative, holistic approaches to the human body, health, and causality of ill health and the lack of social and psychological well-being; and
(F) assist the National Health Board in formulating national policies relating to the promotion of health and the provision of health care.
Subtitle D—Health Planning, Distribution of Drugs and Other Medical Supplies, and Miscellaneous Functions

SEC. 431. HEALTH PLANNING AND BUDGETING.

(a) In General.—Each area health board shall, under guidelines established by the National Health Board, collect data on the supply of and demand for health workers in facilities under its supervision, and on the delivery of health care and supplemental services in health care facilities under its supervision, shall evaluate such data in relation to the health care needs of their respective area, and shall transmit such data and evaluation—

(1) to its respective regional board, in the case of a district or community board, and

(2) to the National Health Board, in the case of a regional board,

and shall make available such data and evaluations to residents of its area.

(b) Coordination.—Each regional board shall coordinate the planning and administration of the delivery of health care services, health worker education, and health research in its region, and shall facilitate the planning and administration of such programs by district and community boards in its region.
(c) PLANS.—The National Health Board shall formulate a 1-year and 5-year national health plan and budget, taking into account the area plans and budgets prepared in accordance with section 522, to provide guidance and direction to area health boards.

SEC. 432. DISTRIBUTION OF DRUGS AND OTHER MEDICAL SUPPLIES.

(a) NATIONAL FORMULARY.—

(1) PUBLICATION.—The National Health Board, after consultation with the regional boards, shall, not later than the effective date of health services, publish and disseminate to area health boards a National Pharmacy and Medical Supply Formulary (in this section referred to as the “Formulary”).

(2) CONTENTS.—The Formulary shall contain a listing of drugs, therapeutic devices, appliances, equipment, and other medical supplies (including eyeglasses, other visual aids, hearing aids, and prosthetic devices) (in this section referred to as “drugs and other medical supplies”). For each item on such listing the Formulary shall contain (A) the standards of quality for the production of such item, (B) the medical conditions for which the item is certified as effective for purposes of the provision of health
care services under this Act, and (C) such other in-
formation on such item as the National Health
Board determines to be appropriate for the effective
and efficient delivery of health care services under
this Act.

(3) UPDATING.—The National Health Board
shall, at regular intervals, update the contents of the
Formulary and publish a price list for items listed
in the Formulary, which prices shall reflect the ac-
tual costs of manufacture.

(b) DRUG PURCHASE PROGRAMS.—

(1) IN GENERAL.—Each regional board shall
establish a program, in accordance with this sub-
section and under guidelines established by the Na-
tional Health Board, for the purchase and distribu-
tion of drugs and other medical supplies for use in
health care facilities established by such board or by
a community or district board within its region.

(2) PRICING.—Such program shall provide for
the purchase of each drug or other medical supply
item only (A) following competitive bidding on such
item or (B) based on the price listed for such item
in the price list published under subsection (a)(3).

(3) GENERIC DISTRIBUTION.—Such program
shall provide for the distribution of drugs (and their
dispensing by community and district boards in its region) under their generic names.

(4) GENERIC NAMES DEFINED.—For purposes of paragraph (3), the term “generic names” means the established names, as defined in section 502(e)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352(e)(2)).

(c) AUTHORITY TO MANUFACTURE.—The National Health Board is authorized to establish and operate drug and medical supply manufacturing facilities, if it determines that such operation will result in reduced expenditures by the Service.

SEC. 433. MISCELLANEOUS FUNCTIONS OF THE NATIONAL HEALTH BOARD.

Sec. 433. (a) ANNUAL REPORT.—The appropriate National Health Board shall publish, not later than December 31 of each year, a report presenting and evaluating operations of the Service during the fiscal year ending in such year and surveying the future health needs of the Nation and plans the Board has for the Service to meet such needs.

(b) DISSEMINATION.—The National Health Board shall, not later than the effective date of health services, prepare and disseminate to area health boards, for use by users, information about health and health services
deemed essential to ensure users’ active and informed participation in the health care system, including information that is culturally appropriate for each area’s principal cultural and ethnic groupings, a comprehensive dictionary of terms used in health care records and services maintained or provided by the Service. Such dictionary shall explain terms related to symptoms, signs, diagnoses, etiologic agents and conditions, diagnostic procedures, and the treatment and prevention of, and rehabilitation following, illnesses, and shall include extensive citations of lay and professional sources which a user might consult for additional information on such terms.

**TITLE V—FINANCING OF THE SERVICE**

**Subtitle A—Health Service Taxes**

**SEC. 501. INDIVIDUAL AND CORPORATE INCOME TAXES.**

(a) Health Service Taxes.—

(1) In general.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to normal taxes and surtaxes) is amended by adding at the end the following new part:

“PART VIII—HEALTH SERVICE TAXES

“Sec. 59B. Tax imposed.
“SEC. 59B. TAX IMPOSED.

“(a) INDIVIDUALS, ESTATES, AND TRUSTS.—In addition to other taxes, there is hereby imposed for each taxable year on the taxable income of every individual and of every estate and trust taxable under section 1(d), a tax in an amount equal to 10 percent of the total tax imposed by section 1 for such taxable year.

“(b) CORPORATION.—In addition to the other taxes, there is hereby imposed for each taxable year on the taxable income of every corporation, a tax in an amount equal to 90 percent of the total amount of the normal tax and surtax imposed by section 11 for such taxable year.”

(2) CLERICAL AMENDMENT.—The table of parts of such subchapter A is amended by adding after the item relating to part VII the following new item:

“Part VIII. Health service taxes.”.

(e) EFFECTIVE DATE.—The amendments made in this section shall apply to taxable years beginning on or after the effective date of health services.


(a) DENIAL OF EXCLUSION FROM GROSS INCOME FOR AMOUNTS PAID BY THIRD PARTIES FOR MEDICAL CARE.—Section 105 of the Internal Revenue Code of 1986
(relating to amounts received under accident and health plans) is amended by striking subsection (b).

(b) DENIAL OF EXCLUSION FROM GROSS INCOME OF CERTAIN CONTRIBUTIONS BY THE EMPLOYER TO HEALTH PLANS.—Subsection (a) of section 106 of such Code (relating to contributions by employer to accident and health plans) is amended to read as follows:

“(a) GENERAL RULE.—Except as otherwise provided in this section, gross income does not include contributions by the employer to accident or health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness to the extent that such contributions do not provide for health care and supplemental services available to such employees under the Josephine Butler United States Health Service Act.”

(e) DENIAL OF DEDUCTION OF HEALTH CARE EXPENSES AS TRADE OR BUSINESS EXPENSES.—Section 162 of such Code (relating to trade or business expenses) is amended by redesignating subsection (p) as subsection (q) and by adding after subsection (o) the following new subsection:

“(p) PAYMENTS FOR HEALTH CARE.—No deduction shall be allowed under subsection (a) for any amount paid for health care services (other than any amount of tax imposed by section 59B and paid by the employer on behalf

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of his employees) which an individual was eligible to re-
ceive under title II of the Josephine Butler United States
Health Service Act.”.

(d) **Denial of Deduction for Contributions to**
**Certain Medical and Hospital Facilities.**—

(1) Paragraph (2) of section 170(c) of such
Code (relating to charitable, etc., contributions and
gifts) is amended by inserting “(other than an orga-
nization described in subsection (b)(1)(A)(iii))” after
“(2) A corporation, trust, or community chest, fund,
or foundation”.

(2) Subsection (e) of section 501 of such Code
(relating to cooperative hospital service organiza-
tions) is amended by striking the last sentence.

(e) **Denial of Deduction for Medical, Dental,
Etc., Expenses.**—

(1) Section 213 of such Code (relating to med-
ical, dental, etc., expenses) is repealed.

(2) The table of sections of part VII of sub-
chapter B of chapter 1 of such Code is amended by
striking the item relating to section 213.

(f) **Hospital Insurance Tax.**—

(1) Subsection (b) of section 1401 of such Code
(relating to rate of tax on self-employment income)
is repealed.
(A) Subsection (b) of section 3101 of such Code (relating to rate of tax on employees under the Federal Insurance Contributions Act) is repealed.

(B) Section 3201(a) of such Code (relating to rate of tax imposed on employees under the Railroad Retirement Tax Act) is amended by striking “subsections (a) and (b)” and inserting “subsection (a)’’.

(C) Section 3211(a)(1) of such Code (relating to rate of tax on employee representatives under the Railroad Retirement Tax Act) is amended by striking “subsections (a) and (b)” and inserting “subsection (a)’’.

(D) Subsection (e) of section 6051 of such Code (relating to railroad employees) is repealed.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning on or after the effective date of health services.

SEC. 503. EXISTING EMPLOYER-EMPLOYEE HEALTH BENEFIT PLANS.

No contractual or other nonstatutory obligation of any employer to pay for or provide any health care and supplemental service to his present and former employees
and their dependents and survivors, or to any of such per-
sons, shall apply on and after the effective date of health
services to the extent such individuals are eligible to re-
cieve such health care and supplemental services under
this Act.

SEC. 504. WORKERS COMPENSATION PROGRAMS.

No workers compensation program, whether estab-
lished pursuant to Federal or State law or private initia-
tive, shall pay for or provide any health care and supple-
mental services on and after the effective date of health
services, to the extent such health care and supplemental
services are available under this Act.

Subtitle B—Health Service Trust
Fund

SEC. 511. ESTABLISHMENT OF HEALTH SERVICE TRUST
FUND.

(a) ESTABLISHMENT.—There is hereby created on
the books of the Treasury of the United States a trust
fund to be known as the Health Service Trust Fund (in
this title referred to as the “Trust Fund”). The Trust
Fund shall consist of such gifts and bequests as may be
made to the Service and such amounts as may be depos-
ited in, or appropriated to, such fund as provided in this
subtitle.
(b) APPROPRIATION.—There is hereby appropriated to the Trust Fund for each fiscal year beginning in the fiscal year in which the effective date of health services (as defined in title VI) falls, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, an amount equal to 100 percent of expected net receipts from the taxes imposed by sections 59B and 3111(b) of the Internal Revenue Code of 1986 (as estimated by the Secretary of the Treasury). The amount appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund in such smaller amounts to be determined on the basis of estimates by the Secretary of the Treasury of the receipts specified in the preceding sentence; and proper adjustments shall be made in the amounts subsequently transferred to the extent prior estimates were in excess of or were less than the receipts specified in such sentence.

SEC. 512. TRANSFER OF FUNDS TO THE HEALTH SERVICE TRUST FUND.

(a) OF MEDICARE TRUST FUNDS.—On the effective date of health services, there are transferred to the Trust Fund all of the assets and liabilities of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.
(b) ADDITIONAL AMOUNTS.—In addition to the sums appropriated by section 511(b), there is appropriated to the Trust Fund for each fiscal year, out of any moneys in the Treasury not otherwise appropriated, a governmental contribution equal to 40 percent of the sums appropriated by section 511(b) for such fiscal year. There shall be deposited in the Trust Fund all recoveries of overpayments, and all receipts under loans or other agreements entered into, under this Act.

SEC. 513. ADMINISTRATION OF HEALTH SERVICE TRUST FUND.

(a) BOARD OF TRUSTEES.—With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (in this section referred to as the “Board of Trustees”) composed of the Secretary of the Treasury, the Secretary of Health and Human Services, and the Chairperson of the National Health Board, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (in this section referred to as the “Managing Trustee”). The Chairperson of the National Health Board shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—
(1) hold the Trust Fund;

(2) report to the Congress not later than the first day of April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

(3) report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

(b) INVESTMENT.—It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund
as is not, in his judgment, required to meet current with-
drawals. Such investments may be made only in interest-
bearing obligations of the United States or in obligations
guaranteed as to both principal and interest by the United
States. For such purpose such obligations may be acquired
(1) on original issue at the issue price, or (2) by purchase
of outstanding obligations at the market price. The pur-
poses for which obligations of the United States may be
issued under the Second Liberty Bond Act, as amended,
are hereby extended to authorize the issuance at par of
public-debt obligations for purchase by the Trust Fund.

(c) ISSUANCE OF OBLIGATIONS.—Any obligations ac-
quired by the Trust Fund (except public-debt obligations
issued exclusively to the Trust Fund) may be sold by the
Managing Trustee at the market price, and such public-
debt obligations may be redeemed at par plus accrued in-
terest.

(d) PAYMENT OF INTEREST.—The interest on, and
the proceeds from the sale or redemption of, any obliga-
tions held in the Trust Fund shall be credited to and form
a part of the Trust Fund.

(e) PAYMENTS.—The Managing Trustee shall pay
from time to time from the Trust Fund such amounts as
the National Health Board certifies are necessary to carry
out this Act.
Subtitle C—Preparation of Plans and Budgets

SEC. 521. DETERMINATION OF FUND AVAILABILITY.

(a) Maximum Funds.—

(1) Fixing.—The National Health Board shall, not later than January 1 of each year, initially fix the maximum amount of funds which may (except as provided in subsection (c)) be obligated during the fiscal year beginning on October 1 of such year for expenditure from the Trust Fund.

(2) Limitation.—Such amount shall not exceed for a fiscal year the lesser of—

(A) 140 percent of the expected net receipts during the fiscal year (as estimated by the Secretary of the Treasury) from the taxes imposed by sections 59 and 3111(b) of the Internal Revenue Code of 1986;

(B) the amount of the aggregate obligations that the National Health Board determines were (or will be) incurred by the Service from the Trust Fund during the previous fiscal year, adjusted to reflect changes in the cost of living, in the number of users, and in the capacity of the Service to provide services under this Act, as such changes are reflected in the plans.
and budgets prepared and submitted by area
health boards under this subtitle; or

(C) the amount fixed under subsection (b).

(3) **REFIXING.**—The National Health Board
may at any time refix such amount to reflect
changes—

(A) of one percent or more in the expected
net tax receipts (described in paragraph
(2)(A)); or

(B) of five percent or more in the cost of
living, number of users, or the capacity of the
Service to provide services under this Act.

The National Health Board shall promptly report to
Congress any increase made in such amount and the
reasons therefor.

(b) **LESSER AMOUNT.**—The National Health Board
shall fix in a fiscal year an amount, which the maximum
amount described in subsection (a)(1) may not exceed in
the fiscal year, which is less than the amount described
in subsection (a)(2)(A) if the Board determines that—

(1) restriction of the amount to be made avail-
able for obligation will not materially impair the ade-
quacy or quality of health care and supplemental
services provided to users, or
(2) improvement in the organization, delivery, or utilization of such services has lessened their aggregate cost (or increase in such cost).

(c) OBLIGATION.—The National Health Board may obligate for expenditure from the Trust Fund, in addition to the maximum amount which may be obligated in a fiscal year under subsection (a), such funds as are necessary to provide health care and supplemental services needed because of an epidemic, disaster, or other occurrence which was not, and could not have been, reasonably planned for by the Board and for which the contingency fund provided in section 534(b)(6) is insufficient. The National Health Board shall promptly report to Congress any obligation made pursuant to this subsection and the reasons therefor.

(d) OBLIGATION OF BORROWED AMOUNTS.—In addition to the maximum amounts which may be obligated pursuant to subsection (a), the National Health Board may allocate funds borrowed in accordance with section 541 for such purposes as it deems necessary and appropriate.

SEC. 522. PREPARATION OF AREA PLANS AND BUDGETS.

(a) COMMUNITY BOARDS.—Each community board shall, not later than January 1 of each year, submit to its respective district board a plan and budget for the fis-
cal year beginning on October 1 of such year. In preparing such plan and budget, each community board shall consult with users and health workers in the community to assure effective and coordinated planning for the efficient use of resources in its community.

(b) District Boards.—Each district board shall, not later than February 1 of each year, submit to its respective regional board a plan and budget for the fiscal year beginning on October 1 of such year. In preparing such plan and budget, each district board shall consult with the users, health workers, and community boards in its district to assure effective and coordinated planning for the efficient use of resources in its district.

(e) Regional Boards.—Each regional board shall, not later than March 1 of each year, submit to the National Health Board a plan and budget for the fiscal year beginning on October 1 of such year. In preparing such plan and budget, each regional board shall consult with the users, health workers, and district boards in its region to assure effective and coordinated planning for the efficient use of resources in its region.

(d) Budget Breakdowns.—In preparing the budgets required by this section, each area health board shall specify its operating, prevention, capital, and research expenses anticipated for the fiscal year covered by the budg-
et and for the 5-year period beginning with such fiscal year.

**Subtitle D—Allocation and Distribution of Funds**

**SEC. 531. NATIONAL BUDGET.**

(a) **Preparation.**—The National Health Board shall prepare, taking into consideration the budgets submitted under section 522(c), and, as soon after April 1 of each year as is practicable, shall transmit to the regional boards a national health budget for the fiscal year beginning on October 1 of such year. Such budget shall divide the total funds available for obligation in such year, as determined under section 521, into—

(1) funds for ordinary operating expenses, which shall be further divided into funds for use by the National Health Board, and funds to be allocated (in accordance with subsection (b)) to the regional boards for use by the regional boards and the district and community boards within their regions;

(2) funds for preventive health measures, which shall be further divided into funds for use by the National Health Board and funds to be allocated (in accordance with subsection (b)) to the regional boards for use by the regional boards and the district and community boards within their regions,
and which measures shall include primary prevention
to improve the conditions under which people live
that affect health status;

(3) funds for capital expenses, which shall be
further divided into funds for use by the National
Health Board and funds to be allocated (in accord-
ance with subsection (e)) to the regional boards for
use by the regional boards and district and commu-
nity boards within their regions;

(4) funds for research expenses, which shall be
further divided into funds for the conduct of re-
search under the supervision of the National Health
Board and funds to be allocated (in accordance with
subsection (b)) to the regional boards for the con-
duct of research under the supervision of the re-
gional, district, and community boards; and

(5) funds for special operating expenses, as de-
scribed in section 534.

(b) ORDINARY OPERATING EXPENSES.—Funds for
ordinary operating expenses, for preventive health meas-
ures, and for research expenses which are allocated to the
regional boards under subsection (a) shall be divided
among the regions in the proportion which the number
of residents in each region bears to the total population
of the Nation.
(c) CAPITAL EXPENSES.—Funds for capital expenses which are allocated to the regional boards under subsection (a) shall be allocated, to the extent consistent with the efficient and equitable use of resources, to the regional boards in accordance with the budgets for capital expenses submitted by such boards to the National Health Board under section 522(c), except that during the first 10 fiscal years following the effective date of health services, priority shall be given to regions lacking adequate health care facilities on such effective date.

(d) ADOPTION.—A budget submitted to the regional boards under subsection (a) shall be adopted upon the approval of such budget by a majority of such regional boards.

SEC. 532. REGIONAL BUDGETS.

(a) PREPARATION.—Each regional board shall prepare, taking into consideration the budgets submitted under section 522(b), and, as soon as may be practicable after the adoption under section 531 of the national health budget for any fiscal year, shall transmit a regional budget, covering operating, prevention, capital, and research expenses for such fiscal year, to each district board in its region. Such regional budget shall be adopted upon the approval of such budget by a majority of such district boards.
(b) CAPITAL EXPENSES.—Funds for capital expenses shall be allocated, to the extent consistent with the efficient and equitable use of resources, to the district boards in a region in accordance with the budgets for capital expenses submitted by such boards to the regional board under section 522(b), except that during the first 10 fiscal years following the effective date of health services, priority shall be given to districts lacking adequate health care facilities on such effective date.

(c) DISTRICT ALLOCATIONS.—Funds to be allocated to district boards for ordinary operating expenses, preventive health measures, and research expenses shall be allocated to each district board in the same proportion as the number of residents in such district bears to the number of residents in the respective region.

SEC. 533. DISTRICT BUDGETS.

(a) PREPARATION.—Each district board shall prepare, taking into consideration the budgets submitted under section 522 (a), and, as soon as may be practicable after the adoption under section 532 of the regional health budget for any fiscal year for the respective region, shall transmit a district budget, covering operating, prevention, capital, and research expenses for such fiscal year, to each community board in its district. Such district budget shall
be adopted upon the approval of such budget by a majority of such community boards.

(b) CAPITAL EXPENSES.—Funds for capital expenses shall be allocated, to the extent consistent with the efficient and equitable use of resources, to the community boards in a district in accordance with the budgets for capital expenses submitted by such boards to the district board under section 522(a), except that during the first 10 fiscal years following the effective date of health services, priority shall be given to communities lacking adequate health care facilities on such effective date.

(c) ALLOCATION FOR COMMUNITY BOARDS.—Funds to be allocated to community boards for ordinary operating expenses, preventive health measures, and research expenses shall be allocated to each community board in the same proportion as the number of residents in such community bears to the number of residents in the respective district.

SEC. 534. SPECIAL OPERATING EXPENSE FUND.

(a) IN GENERAL.—A fund for special operating expenses shall be incorporated into each budget prepared by the National Health Board. For the purposes of this title, the term “special operating expenses” means operating expenses associated with—
(1) the care and treatment of users 65 years of age or older;

(2) the care and treatment of persons confined to full-time residential care institutions, including nursing homes and facilities for the treatment of mental illness;

(3) the special health care needs of low-income users;

(4) the special health care needs of communities of color that experience disparities in health status compared to white populations;

(5) the special health care needs of residents of rural or frontier areas, or non-contiguous states and territories;

(6) special health care needs arising from environmental or occupational health conditions;

(7) special health care needs arising from unexpected occurrences, including epidemics and natural disasters; and

(8) the conduct of environmental health inspection and monitoring services.

(b) ALLOCATION.—The special operating expense fund shall be allocated as follows:

(1) Funds for the additional operating expenses associated with the care and treatment of users 65
years of age or older shall be allocated to district and community boards and shall consist of uniform basic capitation amounts multiplied by the number of residents 65 years of age or older in the respective districts and communities. The basic capitation amounts for districts and for communities shall be determined by the National Health Board, based upon studies of the additional operating expenses associated with the care and treatment of such residents in such districts and communities.

(2) Funds for the additional operating expenses associated with the care and treatment of persons confined to full-time residential care institutions shall be allocated to the district and community boards responsible for such institutions and shall consist of a uniform basic capitation amount for each kind of institution, multiplied by the number of residents in such institutions in the respective districts and communities. The basic capitation amounts shall be determined by the National Health Board, based upon studies of the additional operating expenses associated with the care and treatment of such persons and the maintenance of such institutions.
(3) Funds shall be allocated to community boards for the additional operating expenses associated with the special health care needs of low-income persons. Such payments shall be allocated to community boards in proportion to the number of residents in their communities having incomes below the poverty level (as defined by the Secretary of Commerce). The total funds allocated for this purpose shall be no less than 2 percent of the ordinary operating expense funds allocated in accordance with section 531(a).

(4) Funds shall be allocated to community boards for the additional operating expenses associated with the special health care needs of communities of color to the extent that they experience disparities in health status compared to white populations. The basic capitation amounts shall be determined by the National Health Board, based upon studies of the additional operating expenses associated with providing the necessary or appropriate health services for communities of color, and the additional expenses associated with eliminating such disparities in health status.

(5) Funds for the additional operating expenses associated with the special health care needs of resi-
dents of rural or frontier areas, or non-contiguous states and territories, shall be allocated to district and community boards serving areas of low population density and shall consist of basic capitation amounts multiplied by the number of residents in the respective districts and communities. The basic capitation amounts shall be determined by the National Health Board based upon studies of the additional operating expenses associated with the provision of health care in areas of low population density or extreme geographic access barriers, or both.

(6) Funds for the additional operating expenses associated with special regional health care needs arising from environmental and occupational health problems shall be allocated to regional boards by the National Health Board in accordance with its determination of such special needs. The total funds allocated for this purpose shall be no greater than one-half of 1 percent of the ordinary operating expense funds allocated in accordance with section 531(a).

(7) Funds for the additional operating expenses associated with special health care needs arising from unexpected occurrences shall be retained by the National Health Board in a contingency fund and shall be allocated by the National Health Board in
accordance with its determination of such needs. The total funds retained for this purpose in any one fiscal year shall be no greater than one-half of 1 percent of the ordinary operating expense funds allocated in such year in accordance with section 531(a).

(8) Funds for the additional operating expenses associated with the conduct of environmental health inspection and monitoring services shall be allocated by the National Health Board to the area health boards providing such services.

SEC. 535. DISTRIBUTION OF FUNDS.

(a) In General.—Funds allocated under the national health budget shall be distributed by the National Health Board from the Trust Fund. No health board may request or receive funds from any other source.

(b) Payments and Expenditures.—All payments shall be made to area health boards, and shall be expended by such boards, in accordance with the budgets adopted under sections 531 through 533. If the budget for any area health board for a fiscal year is not adopted before the beginning of the fiscal year, until such budget is adopted such area health board shall continue to receive ordinary operating expense funds, prevention expense funds, and research expense funds at the rate at which it was
receiving such funds during the preceding fiscal year, and
it shall receive special operating expense funds in accord-
ance with section 534.

(c) ACCOUNTS.—Each area health board shall main-
tain separate accounts for—

(1) funds for operating expenses, including or-
dinary operating expenses and special operating ex-
penses;

(2) funds for preventive health measures;

(3) funds for capital expenses; and

(4) funds for research expenses.

Funds in a capital expense account shall be expended only
for capital expenses. Funds in a research expense account
shall be expended only for operations, equipment, and fa-
cilities for health and health care delivery research con-
ducted in accordance with subtitle C of title IV. Separate
accounts shall not be required for funds for ordinary oper-
ating expenses and for special operating expenses.

(d) PAYMENT FREQUENCY.—Area health boards
shall be paid at such time or times as the National Health
Board finds appropriate.

(e) ALLOCATION OF SUPPLEMENTARY PAYMENTS.—
Before and during any fiscal year, supplementary funds
may be allocated to any area health board if the National
Health Board finds that such funds are required by events
occurring or information acquired after the initial allocations to such health board were made.

(f) USE OF FUNDS.—Area health boards may retain funds received from the National Health Board for 2 years following the receipt of such funds. Any funds which are unexpended after such time shall be returned to the National Health Board for deposit in the Trust Fund.

SEC. 536. ANNUAL STATEMENT, RECORDS, AND AUDITS.

(a) ANNUAL STATEMENT.—Each area health board shall prepare annually and transmit to the National Health Board a statement which shall accurately show the financial operations of such board and the facilities supervised by it for the year for which such statement is prepared.

(b) RECORD KEEPING.—Each area health board shall keep such records as the National Health Board determines to be necessary for the purposes of this Act, including for the facilitation of audits.

(c) AUDITS.—The National Health Board and the Comptroller General of the United States, or their duly authorized representatives, shall, for the purpose of audits, have access to any books, documents, papers, and records which in their opinion are related or pertinent to the operation of the Service.
Subtitle E—General Provisions

SEC. 541. ISSUANCE OF OBLIGATIONS.

(a) Borrowing Authority.—The National Health Board is authorized to borrow money and to issue and sell such obligations as it determines necessary to carry out the purposes of this Act, but only in such amounts as may be specified from time to time in appropriation Acts. The aggregate amount of any such obligations outstanding at any one time shall not exceed $10,000,000,000.

(b) Pledging of Assets.—The National Health Board may pledge the assets of the Trust Fund and pledge and use its revenues and receipts for the payment of the principal of or interest on such obligations, for the purchase or redemption thereof, and for other purposes incidental thereto. The National Health Board is authorized to enter into binding covenants with the holders of such obligations, and with the trustee, if any, under any agreement entered into in connection with the issuance thereof with respect to the establishment of reserve, sinking, and other funds, stipulations concerning the issuance of obligations or the execution of leases or lease purchases relating to properties of the Service and such other matters as the National Health Board deems necessary or desirable to enhance the marketability of such obligations.
(c) **FORM OF OBLIGATIONS.**—Obligations issued by the Service under this section—

1. shall be in such forms and denominations;
2. shall be sold at such times and in such amounts;
3. shall mature at such time or times;
4. shall be sold at such prices;
5. shall bear such rates of interest;
6. may be redeemable before maturity in such manner, at such times, and at such redemption premiums;
7. may be entitled to such relative priorities of claim on the assets of the Service with respect to principal and interest payments; and
8. shall be subject to other terms and conditions, as the National Health Board determines.

(d) **CHARACTER OF OBLIGATIONS.**—Obligations issued by the Service under this section shall—

1. be negotiable or nonnegotiable and bearer or registered instruments, as specified therein and in any indenture or covenant relating thereto;
2. contain a recital that they are issued under this section, and such recital shall be conclusive evidence of the regularity of the issuance and sale of such obligations and of their validity;
(3) be lawful investments and may be accepted as security for all fiduciary, trust, and public funds, the investment or deposit of which shall be under the authority or control of any officer or agency of the Government of the United States, and the Secretary of the Treasury or any other officer or agency having authority over or control of any such fiduciary, trust, or public funds, may at any time sell any of the obligations of the Service acquired under this section;

(4) be exempt both as to principal and interest from all taxation now or hereafter imposed by any State or local taxing authority except estate, inheritance, and gift taxes; and

(5) not be obligations of, nor shall payment of the principal thereof or interest thereon be guaranteed by, the Government of the United States, except as provided in subsection (g).

(e) CONSULTATION WITH TREASURY.—At least 15 days before selling any issue of obligations, the National Health Board shall advise the Secretary of the Treasury of the amount, proposed date of sale, maturities, terms and conditions, and expected maximum rates of interest of the proposed issue in appropriate detail and shall consult with him or his designee thereon. The Secretary may
elect to purchase such obligations under such terms, in-
cluding rates of interest, as he and the National Health
Board may agree, but at a rate of yield no less than the
prevailing yield on outstanding marketable Treasury secu-
rities of comparable maturity, as determined by the Sec-
retary. If the Secretary does not purchase such obliga-
tions, the National Health Board may proceed to issue
and sell them to a party or parties other than the Sec-
retary upon notice to the Secretary and upon consultation
as to the date of issuance, maximum rates of interest, and
other terms and conditions.

(f) PURCHASE OF OBLIGATIONS.—Subject to the
conditions of subsection (e), the National Health Board
may require the Secretary of the Treasury to purchase ob-
ligations of the Service in such amounts as will not cause
the holding by the Secretary of the Treasury resulting
from such required purchases to exceed $2,000,000,000
at any one time. This subsection shall not be construed
as limiting the authority of the Secretary to purchase obli-
gations of the Service in excess of such amount.

(g) FULL FAITH AND CREDIT.—Notwithstanding
subsection (d)(5), obligations issued by the Service shall
be obligations of the Government of the United States,
and payment of principal and interest thereon shall be
fully guaranteed by the Government of the United States,
such guaranty being expressed on the face thereof, if and
to the extent that—

(1) the National Health Board requests the
Secretary of the Treasury to pledge the full faith
and credit of the Government of the United States
for the payment of principal and interest thereon;
and

(2) the Secretary, in his discretion, determines
that it would be in the public interest to do so.

(h) PUBLIC DEBT TRANSACTION.—For the purpose
of any purchase of the obligations of the Service, the Sec-
retary of the Treasury is authorized to use as a public
debt transaction the proceeds from the sale of any securi-
ties issued under the Second Liberty Bond Act, as now
or hereafter in force, and the purposes for which securities
may be issued under the Second Liberty Bond Act, as now
or hereafter in force, are extended to include any pur-
chases of the obligations of the Service under this subtitle.
The Secretary of the Treasury may, at any time, sell any
of the obligations of the Service acquired by him under
this chapter. All redemptions, purchases, and sales by the
Secretary of the obligations of the Service shall be treated
as public debt transactions of the United States.

SEC. 542. DEFINITIONS.

For purposes of this title:
(1) Operating expenses.—The term “operating expenses” means the cost of providing, planning, operating, and maintaining services, facilities, programs, and boards (other than those associated with research) established or furnished under this Act, and of capital buildings and equipment (other than those associated with research) costing less than $100,000, except for funds associated with the conduct of preventive health measures and research.

(2) Capital expenses.—The term “capital expenses” means expenses which under generally accepted accounting principles are not properly chargeable as expenses of operation and maintenance, which exceed $100,000, and which are not associated primarily with the conduct of research.

TITLE VI—MISCELLANEOUS PROVISIONS

SEC. 601. EFFECTIVE DATE OF HEALTH SERVICES.

The effective date of health services under this Act is January 1 of the fourth calendar year after the year in which this Act is enacted.

SEC. 602. REPEAL OF PROVISIONS.

(a) In general.—Effective on the effective date of health services, the following provisions of law are repealed:
(1) The Public Health Service Act, except for—

(A) title I (relating to short title and definitions), parts F and G of title III (relating to licensing and quarantine authority), and title XIV (relating to safety of public water systems); and

(B) titles VII and VIII, which shall remain effective, during the period beginning on such effective date and ending on the date occurring 4 years after such effective date, with respect to the provision of assistance to educational institutions, and students thereof, in areas which have not established health team schools under subtitle A of title III of this Act.

(2) Titles V, XVIII, and XIX of the Social Security Act (relating to the maternal and child health and crippled children's services, Medicare, and Medicaid); part B of title XI of such Act (relating to professional standards review); sections 226, 1121 through 1124, and 1126 of such Act (relating to entitlement to hospital insurance benefits, uniform health reporting systems, limitation on Federal participation for capital expenditures, program for determining qualification for certain health care personnel, disclosure of ownership and related informa-
tion, and disclosure of certain convictions); and so
much of title XX of such Act (relating to grants to
States for services) as provides for payments to
States for health care and supplemental services.

(3) Chapter 89 of title 5, United States Code
(relating to health insurance for Federal employees).

(4) Chapters 17, 73, and 81 and section 1506
of title 38, United States Code (relating to medical
benefits and programs relating to veterans).

(5) Sections 1079 through 1083 and section
1086 of title 10, United States Code (relating to the
civilian health and medical program of the uni-
formed services).

(6) The Comprehensive Alcohol Abuse and Al-
coholism Prevention, Treatment, and Rehabilitation
Act of 1970; the Comprehensive Alcohol Abuse and
Alcoholism Prevention, Treatment, and Rehabilita-
tion Act Amendments of 1974; and section 4 of the
Comprehensive Drug Abuse Prevention and Control
Act of 1970 (relating to medical treatment of nar-
cotic addiction).

2004b) (relating to hospital and other health facili-
ties for Indians) and Public Law 85–151 (42 U.S.C.


(9) Sections 232 and 242 and title XI of the National Housing Act (relating to mortgage insurance for nursing homes, hospitals, and group practice facilities).


(13) Titles I and II and section 301 of the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. 4801, 4811, 4821) (relating to grant programs for lead-based paint poisoning prevention).


(15) Subsection (e) of section 20 and section 22 of the Occupational Safety and Health Act of 1970.
(relating to the National Institute for Occupational Safety and Health).

(b) PREPARATION OF ADDITIONAL LIST.—

(1) IN GENERAL.—Not later than three years after the date of enactment of this Act, the President shall prepare, in consultation with the appropriate National Health Board, and transmit to Congress legislation—

(A) to repeal or amend such provisions of law as are inconsistent with the purposes of this Act or the provision of health care and supplemental services by the Service under this Act; and

(B) to make such conforming and technical amendments in provisions of law as may be necessary to properly effect the repeal of provisions described in subsection (a) and the repeal or amendment of provisions described in subparagraph (A) of this paragraph.

(2) TRANSFER AUTHORITY.—Such legislation shall include the transfers of such authority of the Secretary of Health and Human Services under the provisions of—

(A) the Controlled Substances Act;
(B) chapter 175 of title 28, United States
Code (relating to civil commitment and rehabilitation of narcotics addicts);

(C) chapter 314 of title 18, United States
Code (relating to sentencing of narcotic addicts to commitment for treatment);

(D) the Narcotic Addict Rehabilitation Act of 1966;

(E) the Drug Abuse Office and Treatment Act of 1972;

(F) the Occupational Safety and Health Act of 1970;

(G) the Lead-Based Paint Poisoning Prevention Act;

(H) the Federal Cigarette Labeling and Advertising Act;

(I) the Federal Food, Drug, and Cosmetic Act;

(J) the Fair Packaging and Labeling Act;

(K) the Act of March 4, 1923 (21 U.S.C. 61–64) (relating to filled milk);

(L) the Act of February 15, 1927 (21 U.S.C. 141–149) (relating to milk importation);

(M) the Federal Caustic Poison Act;
(N) the Federal Coal Mine Health and Safety Act of 1969 (other than title IV there-
of); and

(O) the Solid Waste Disposal Act,

to the Service as the President determines, after consultation with the National Health Board, to be appropriate.

(c) Review of Programs.—

(1) In General.—The National Health Board shall, immediately upon its initial appointment, and in consultation with the Secretary of Health and Human Services, review the programs conducted under the specified provisions of the Public Health Service Act and the other Acts described in section 602(a) and shall determine how the Service shall carry out the purposes of such programs.

(2) Initial Report.—Not later than one year after the effective date of health services, the National Health Board shall report to the President and to the Congress on how the Service is carrying out the purposes of the programs authorized to be conducted under provisions of law which are repealed by subsection (a) (other than paragraph (1)(B) thereof).
(3) LATER REPORT.—Not later than 5 years after the effective date of health services, the National Health Board shall report to the President and to the Congress on how the Service is carrying out the purposes of programs described in subsection (a)(1)(B).

(d) CODIFICATION PROPOSAL.—Not later than 2 years after the effective date of health services, the National Health Board shall transmit to Congress a proposed codification of all the provisions of law which contain functions that are transferred or relate to the Service.

SEC. 603. TRANSITION PROVISIONS.

(a) TRANSFER OF APPROPRIATIONS.—Amounts appropriated to carry out the purposes of any provisions of law repealed by this Act and available on the effective date of such repeal shall be transferred on such date to the Health Service Trust Fund (established under section 511 of this Act).

(b) TRANSFER OF PERSONNEL, ASSETS, ETC.—The President is authorized to transfer so much of the positions, personnel, assets, liabilities, contracts, property, and records employed, held, used, arising from, available to or made available in connection with the functions or programs repealed by this Act to the Service as may be
agreed upon by the President and the National Health Board.

(c) Lapses of Offices.—In the case where the authority for the establishment of any office or agency, or all the functions of such office or agency, are repealed under section 602, such office or agency shall lapse.

(d) Application of Amendments.—The amendments made by section 602—

(1) shall not apply with respect to any contract entered into before the effective date of such amendments, and

(2) shall not affect (A) any right or obligation arising out of any matter occurring before the effective date of such amendments, or (B) any administrative or judicial proceeding (whether or not initiated before that date) for the adjudication or enforcement of any such right or obligation.

SEC. 604. AMENDMENT TO BUDGET AND ACCOUNTING ACT.

(a) Health Service Budget.—Section 1105 of title 31, United States Code, is amended by adding at the end the following new subsection:

“(h) The Budget transmitted pursuant to subsection (a) shall set forth the items enumerated in paragraphs (4) through (9) and (12) of subsection (a) with respect to expenditures from and appropriations to the Health Service
Trust Fund (established under section 511 of the Jose-
phine Butler United States Health Service Act) separately
from such items with respect to expenditures and appro-
priations relating to other operations of the Government.”.

(b) **Effective Date.**—The amendment made by
subsection (a) shall apply with respect to fiscal years be-
beginning more than 1 year after the date of enactment of
this Act.

**SEC. 605. SEPARABILITY.**

If any provision of this Act, or the application of such
provision to any person or circumstance, shall be held in-
valid, the remainder of this Act, or the application of such
provision to persons or circumstances other than those as
to which it is held invalid, shall not be affected thereby.

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