world, disregarding the sovereignty of others and policing everyone else's ethics in a hopeless attempt to reform mankind. Not at all. It would instead simply require corporations based in our own country to adhere, wherever they operated, to a standard that served U.S. national interests. Our antitrust, Trading with the Enemy, and other statutes have long been held to have similar extraterritorial application. Setting a good example does not require any other government to follow it.

Of course, it would be preferable if every commercially important government in the world not only enacted but enforced tough and comprehensive laws against the payment and receipt of bribes. That would avoid any adverse competitive consequences of unilateral U.S. action. But awaiting development of an international code by the OECD, GATT, IMF or the United Nations is largely an excuse for delay and inaction. Most of the members of these organizations are not in agreement on what should be done, and many are not enthusiastic about doing anything. Such codes, if they were to be truly meaningful and enforced, would have to sink to the level of the lowest common denominator. Mild admonitions from the OECD and generalized resolutions from the United Nations are the best they are likely to produce.

The United States will be in a stronger position to call for action from other countries, and to embarrass or otherwise pressure any U.S. companies' competitors who are still paying bribes, after we have taken effective action against our own unethical corporations in this regard. Inasmuch as Congress is already past the halfway mark in an election-year session, enactment of new legislation may as well await a fuller determination this year of the entire range of the problem—lest American business be confronted with an incomplete statute constantanly undergoing amendment. Nevertheless it should be already clear to our Congress that our present laws are not adequate, and that action should be taken next year before public interest in the problem flags.

Apart from the illegality of deducting such payments on U.S. tax returns, the principal statutory tool by watch U.S. companies can currently be called to account is the variety of disclosure requirements in the Securities Acts. In addition, Congress has recently called for further disclosures with respect to military sales under the latest foreign aid legislation; and a similar emphasis on disclosure is contained in most of the other legislative proposals on overseas bribery.

This emphasis is well placed. Sunlight, in the memorable phrase of Justice Brandeis, is still the best disinfectant. A company legally required to expose its bribes—and thus face whatever stockholder suits, public embarrassment and government penalties may follow—is less likely to make these payments in the first place and their collaborators are less likely to demand them.

But our present disclosure laws must be strengthened: to impose more severe and certain criminal as well as civil penalties for those who fail to disclose to the appropriate U.S. government authorities any payments abroad, including legitimate political contributions and agents' fees, of a significant amount; to cover privately owned companies as well as those subject to SEC jurisdiction (indeed the SEC may not be the appropriate enforcement agency); to cover exporters of civilian as well as military goods; to cover requests received (as is true of current U.S. Commerce Department regulations concerning the Arab boycott) as well as payments made; and to prohibit more precisely the many techniques used to conceal these practices from corporate and governmental accountability systems.

Disclosure, however, cannot carry the whole burden of law enforcement. It would be illogical to punish more severely than at present the nondisclosure of an activity not now illegal under U.S. law. Moreover, when the general or stockholding public proves to be indifferent to a company's disclosures of wrongdoing, as is often the case, no penalty and no reform may follow.

The more direct and traditional approach to law enforcement is simply to outlaw the payment of bribes and kickbacks to foreign officials by all U.S. corporations and their subsidiaries. Many corporate officials would actually be relieved by such legislation; for it would better enable them to resist all temptations and pressures and to hold both their subordinates and at least their U.S. competitors to a higher standard. It would also provide a stronger legal basis for independent auditors, directors and lawyers—as well as federal authorities—to insist in suspicious cases upon a closer look at the books. It would communicate to every company and government the clearest possible statement of our national integrity.

Such a law would have to be drawn and enforced with great care and precision, carefully setting forth the dinstinctions between bribery and the other forms of payments described above, and not undertaking to enforce what it cannot reach without placing numerous police agents in every U.S. Embassy. Unenforced and unenforceable laws only engender disrespect.

Nor should compliance with a host country's laws be available as a defense under this new statute. Too many of those laws are ambiguous, incomprehensible or unenforced, and the United States cannot undertake to enforce them. Nor, in some countries, is compliance with the law much proof of propriety.

No matter how carefully the new statute is drafted and implemented, however, some improper practices will escape and some new ones will be invented to circumvent it. A foreign agent who acts as an independent contractor for several companies will be able, on his own initiative and with his own funds, without the knowledge or reimbursement of a principal, to make improper payments on that principal's behalf that no outside law can reach U.S. corporations wishing to avoid the law by selling to truly independent local distributors who in turn resell to the local government, complete with kickbacks, will no doubt be able to do so, at least diminishing the impact of their conduct on the United States. Extremely difficult problems of definition, fact-finding and interpretation, such as the seven examples earlier cited, will be frequent.

But the courts and Congress are not unaccustomed to drawing fine lines of distinction. Many another law now on the books is frequently violated but nevertheless desirable as a national standard, even if some violations go undetected. With a strengthened disclosure statute, whatever federal agency is enforcing the law will not be without tools to judge the legality of a suspect payment.

The new law could also regulate the use of agents. To prohibit their use would be outlandish, curbing many legitimate practices and merely causing those intent on paying bribes to conceal them elsewhere. To impose a maximum commission rate would only penalize "small-ticket" sales. But U.S.-based corporations could be required (1) to disclose to the U.S. enforcement agency not only every sizable fee or commission paid overseas but also the services for which it is paid and the recipient's qualifications therefor; (2) to instruct the agent by contract to make no payments to or for government officials and no political contributions on its behalf or with its funds; and (3) to obtain the explicit approval of the host government for that contract and for the agent's rate of compensation. Honest and qualified agents will, on the whole, accept such conditions; those intent on dishonesty will not.

Still other new legislative or executive measures could empower the executive branch to take supplementary action. Violators should be warned that the U.S. government would terminate their eligibility for government contracts and impose no obstacle to their extradition to any country possessing actual proof of their wrongdoing. Any U.S. business executive receiving from a foreign official a request or a demand for improper payments should be required to report it promptly to the U.S. Embassy, which should be required to protest vigorously to the host government. Foreign countries and companies persisting in such practices to the detriment of U.S. economic interests should be warned of the possibility of economic retaliation, ranging from termination of economic and military assistance to denial of access to our domestic markets or stock exchange listings.

Even though a strong international code is not in the offing, the Department of State should undertake to obtain in advance the approval of all affected governments for each of the legislative measures proposed above. Whatever their real feelings, they would find it difficult to object; and such a step would both dampen the cries that such legislation was imposing our standards upon the rest of the world and improve the prospects for its general effectiveness.

It is to be hoped that such laws will also be accompanied by an increased demonstration of corporate self-regulation. In light of recent revelations, this will never be an acceptable substitute for government measures. But it will still be the most effective form of regulation, if enforced, because management can establish a system of clearances for "unusual" or "potentially embarrassing" payments out in the field that no law can adequately reach. Any new legislation and its administration should thus recognize and encourage company initiatives of this kind.

That will require, however, something more than the recent public relations announcements of companies rushing to "reemphasize long-standing policy" by the issuance of new corporate practice guidelines which are either too vague to be meaningful ("do nothing unlawful or improper"); carefully designed not to interfere with their particular practices ("do not violate local law, local custom or U.S. law; make no payments to the foreign government officials responsible for our industry"); or otherwise ineffective, by design or inadvertence.

Companies no more than governments should attempt to enforce what they cannot realistically reach. But a strict, comprehensive company code should be implemented by prompt disciplinary action, including dismissal at any level for violations; by annual sworn certifications of compliance by all responsible members of management; and by a system of full disclosure to counsel and auditors as well as superiors. Such measures, if accompanied by a reduction in pressure in the field to obtain contracts by whatever means necessary, would be far more effective than the recent proposal authorizing the government to remove the chief executive of an offending company.

In evaluating governments as well as private regulation in this area, Americans should bear in mind a wise conclusion of John J. McCloy and his associates in their landmark investigation of the Gulf Oil Corporation's payments at home and abroad. "[I]t is not in the institution of rules and procedures," said that report, that the answer to this problem lies "as much as it . . . is in the tone and purpose given to the Company by its top management."

The same is true of our country.

THE STRUGGLE TO STAY HEALTHY

Mr. HOLLINGS. Mr. President, the current issue of Time magazine contains

a superb Bicentennial essay entitled, "The Struggle to Stay Healthy," written by Dr. John H. Knowles, president of the Rockefeller Foundation. It is a succinct look at 200 years of medical progress, and it demonstrates the remarkable advances which have been made during these years. Indeed, it is hard to believe how far we have come in so short a span of man's history. We are a healthier people enjoying significantly longer lives than did our early American ancestors.

With equal cogency, Dr. Knowles discusses the problems which have accompanied the progress. The expanding utilization of complex medical technology, for instance, has been accompanied by a decline in the personal doctor/patient relationship. And the cost of medical care has escalated so high that many Americans cannot afford to participate in preventive health care. Serious disease can spell financial as well as personal disaster to most American families. And, in the land of plenty, nearly 25 million poor people stand in dire nutritional and medical need. The list of problems goes on.

I was interested in some of the figures cited by Dr. Knowles. He mentions that in 1904, we had in this country 160 medical schools. Today we have only 114. In spite of the qualitative improvements of these schools, the decline in number is not encouraging. I noted also the increasing percentage of foreign medical school graduates practicing in the United States—since 1959 their number has quintupled. Obviously we need to be doing a better job of opening medical educational opportunities to our own youth, with the kind of incentives that will provide the maximal distribution of doctors and health care throughout all regions of the country.

Mr. President, I commend this essay to the attention of my colleagues. I hope they will take a few minutes to read it over, and for that purpose, I ask unanimous consent that the article be printed in the CONGRESSIONAL RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From Time Magazine, Aug. 9, 1976]

THE STRUGGLE TO STAY HEALTHY

(By John H. Knowles, M.D.)

NOTE: *The following Bicentennial Essay is the eighth in a series that has been appearing periodically, surveying how we have changed in our 200 years.*

On the eve of the Revolution, there were 2.5 million people in colonial America. Virginian William Byrd wrote, "It was a Place free from those three great Scourges of Mankind—Priests, Lawyers, and Physicians." Divine aid was considered more important than that of the physician. Only through God's grace could one escape disease or survive its attack. In *The Angel of Bethesda*, the first general treatise on medicine written in the colonies, Cotton Mather advised in 1724, "Let us look upon Sin as the Cause of sickness."

Average life expectancy at birth was 34.5 years for men and 36.5 years for women. Fifty percent of deaths occurred in those under ten years of age. Infectious diseases decimated the population. Smallpox and yellow fever were most feared. Tuberculosis, cholera and dysentery, typhoid, diphtheria, measles and mumps were ever present. Malaria was as common in New England as on the Southern plantations. In 1721, almost half the population of Boston caught smallpox, and more than 7% died. Yellow fever wiped out 10% of the population of Philadelphia in 1793.

Scurvy, scrofula and scabies were common among the poor. Bathing was rare: one Quaker lady noted in her diary in 1789 that she withstood a shower bath "better than I expected, not having been wett all over at once, for 28 years past." Body lice were omnipresent, as was the disease they carried—typhus fever. Frequent births and poor obstetrics accounted for the high mortality in mothers; the death rate among black women served by midwives was lower than among whites served by physicians. Mental illness was seen as the work of the devil: the village idiot was either derided or tolerated, while the more violent were shackled and jailed.

There were 3,500 medical practitioners in the colonies when the Revolution began, of whom fewer than 200 held degrees from medical schools. One writer noted that "with a few, honorable exceptions in each city, the practitioners were ignorant, degraded and contemptible." Quacks abounded. In the North, ministers and magistrates doubled as physicians, while in the South, planters and their wives cared for the slaves. Some of these individuals brought status to the profession. The people viewed the medical profession in general, however, with a mixture of fear, contempt and amiable tolerance. There simply was little that doctors could offer, and their cures were sometimes worse than the diseases that afflicted people.

Purging, emetics and bloodletting were common remedies; surgery consisted of "cutting for stone" and amputations. With no anaesthesia, the best surgeons were the ones who could cut, hack and saw most rapidly, aided by the strongest assistants to hold the patient down. Herbs and plants were extensively used in treatment. Governor John Winthrop of Massachusetts Bay prescribed a paste of wood lice, while Cotton Mather—who together with Zabdiel Boylston brought inoculation to the colonies in 1721 to prevent serious cases of smallpox—condemned the use by Boston physicians of "Leaden Bullets," to be swallowed for "that miserable Distemper which they called the Twisting of the Guts." By the early 18th century, there were only two drugs known to be specific: cinchona bark for malaria, and mercury as an antisyphilitic agent. Dr. Benjamin Rush of Philadelphia (one of four physicians to sign the Declaration of Independence) used bloodletting so extensively that even his colleagues marveled at the survival of his patients. Thomas Jefferson said in 1807, "The patient . . . sometimes gets well in spite of the medicine."

The apprentice system of medical education held sway. The apprentice might pay the master £100 annually for as long as seven years until he "qualified" to practice on his own. By the mid-18th century, more formal training began to take hold. In 1765, after a tour of medical centers in London, Paris, Padua and Edinburgh, John Morgan persuaded the College of Philadelphia to set up the first American medical school. The prototype of the British voluntary hospital was established with the founding of the Pennsylvania Hospital in 1751, the New York in 1771 and the Massachusetts General in 1811, moving the care of the sick poor and the teaching of medical students out of the almshouses. With the founding of the first mental hospital, the Virginia "insane asylum" at Williamsburg, shortly before the Revolution, the mentally ill began to be moved from jails and almshouses to state-sponsored, more humane institutions. Early on, the great cost of mental illness precluded voluntary efforts to care for people of ordinary means.

The institutionalization of a loosely organized profession grew with the founding of state medical societies, teaching hospitals and medical schools. Largely because of the devastation caused by infectious diseases, local communities were forced to form boards of health, which established quarantine measures and tried to provide for sanitary engineering. Infectious disease was thought to be the result of noxious vapors emanating from decaying animal and vegetable matter. Therefore, in addition to isolating feverish individuals, much of the health boards' time was spent attempting to improve sewage and garbage disposal.

The 19th century in Europe saw the emergence of modern medicine. Vaccination for smallpox was introduced. The stethoscope, clinical thermometer and hypodermic syringe were developed. Morphine and quinine were isolated. Surgical instruments were perfected, antiseptic techniques were developed, and the use of ether as an anaesthetic agent was demonstrated in 1846 at the Massachusetts General Hospital—the single most important contribution of American medicine during the century. Pasteur, Koch, Klebs, Roux and Yersin established the science of bacteriology, and between 1880 and 1900 the microbial origins of numerous diseases were demonstrated. A new interest in nutrition developed.

In 1895 two events took place that would have a profound effect on the progress of American medicine: 1) the discovery of a "new kind of rays" by Roentgen, which led to the development of diagnostic radiology and X-ray therapy; and 2) the development of psychoanalytic psychiatry through the studies of Sigmund Freud. In the same way, the accurate diagnosis of many diseases was virtually impossible before the advent of two major technologies in the early part of the 20th century: 1) the chemistry of blood and bodily fluids, which made easier the study of the body's organ systems; and 2) the use of the X-ray machine and the progressive development of such radiopaque substances as barium and iodine compounds to visualize organ systems. These two advances, together with the expansion of surgery after the introduction of anaesthesia and antiseptic techniques, transformed the hospital. From a passive receptacle for the sick poor, it became a house of hope and an active diagnostic and curative institution for all classes. The use of blood transfusions hastened the transformation.

The new sciences of bacteriology, biostatistics and epidemiology led to development and extensive use of vaccines, pasteurization of milk and measures for the control of disease. These advances led to a marked improvement in public health. So did the development of urban sewage-disposal and water-purification systems, the rapid transportation of fresh food and its storage under refrigeration, state food-control acts and the new concern for woman and child labor, as well as for industrial working conditions. By 1910 average life expectancy at birth had increased to 50 years.

The Progressive Era also profoundly affected health interests. Upton Sinclair's *The Jungle*, in 1906, exposed abysmal conditions in meat-packing plants. Congress responded by passing the first meat-inspection law. Samuel Hopkins Adams muckraked the patent-medicine industry, and Congress swiftly enacted the Pure Food and Drug Act.

In 1904 there were 160 medical schools with 28,142 students and 5,747 graduates annually. Abraham Flexner, an educator, not a physician, was commissioned by the Carnegie Foundation for the Advancement of Teaching to study the situation. He recommended the closing or reorganization of all substandard proprietary schools. By 1920 there were only 73 schools with a total of 21,527 students and 4,595 graduates annually. Little significant expansion of medical

schools occurred for the next 20 years, but the "Flexner revolution" helped make the U.S. the world leader in biomedical science and medical education. From 1901 through 1939, the number of Nobel prizes in medicine totaled 42, of which only eight were awarded to Americans. From 1943 to 1975, Americans won 41 of the 74 prizes awarded.

With expanding knowledge and technology, an inevitable subdivision of labor occurred. The general practitioner faced extinction as medical students entered a wide variety of specialties. Specialization advanced to the point where what happened to the patient all too often depended on who saw him first. "Free market" medicine resulted in a gross geographic and functional maldistribution of doctors. There developed a severe oversupply of specialists in some areas (surgery, where work weeks declined as fees rose) and an undersupply in others (pediatric psychiatry and general practice). The g.p. declined from 64% of the total number of doctors in 1949 to 13% in 1973. Meanwhile, the number of graduates of foreign medical schools practicing in the U.S. increased from 20,575, or 8.6% of the total in 1959, to 69,000, or 20% in 1971.

The increasing use of medical technology, while markedly enhancing accuracy of diagnosis and success of treatment, was accompanied by less time spent with patients. Complaints about the dehumanizing of medical care were increasingly heard. Doctors moved their offices close to the hospital and its technology. By the 1950s the house call had virtually vanished as doctor and patient met in the emergency wards and clinics of urban teaching hospitals or in offices next door.

Acute, curative, technology-dependent medicine reached its apogee in the 1960s—and, as expectations rose, so did the costs. The expense of medical care had reached a critical stage with the Depression of 1929–32, when individuals found it increasingly difficult to pay their medical bills. The private sector in the 1930s developed the Blue Cross-Blue Shield insurance system of prepayment for hospitals and physicians. In the public sector, the Social Security mechanism and general tax revenues were used to pay the costs of the indigent sick, the disabled, the elderly and such special groups as veterans, migrant farmers and American Indians. A variety of amendments to the Social Security Act of 1935 culminated in Medicaid (a federal, state and local program for financing medical-care needs of the indigent sick) and Medicare (compulsory health insurance for the elderly). Today 21 million Americans aged 65 and over have such insurance for hospitals and extended-care costs.

The total national expenditure for health in fiscal 1975 was $118.5 billion, which included $46.6 billion for hospital care, $22.1 billion for physician services, $10.6 billion for drugs, $9 billion for nursing-home care, $7.5 billion for dentists' services, $3.5 billion for Government public helath activities and $2.8 billion for medical research. Third-party payments (public and private) for medical care increased from 36% in 1950 to nearly 70% in 1975, thus leaving about 30% of the total to direct payments by the beneficiaries—a significant burden. Hospitals, physicians and drugs consumed almost 70% of the total expenditure. Gross overuse of all three has become a major problem.

The consumer movement focused on the skyrocketing costs of medical care, questioning doctors' fees and incomes, their unavailability and the amounts of unnecessary surgery. Mass media joined the assault, along with those largely liberal politicians trying to generate support for national health insurance as the antidote. The American Medical Association was increasingly viewed as a guild, mostly interested in the welfare of its own members. Nonetheless, virtually every poll of attitudes toward different occupations continues to show that the American physician ranks No. 1 and enjoys immense prestige, exceeding that of Senators and Supreme Court Justices. My doctor is great—it's *those* doctors!

Where do we stand today, and what are our prospects for health beyond 1976? Gone are the scourges of smallpox, yellow fever, tuberculosis, measles and infantile diarrhea. Life expectancy has increased from 47.3 years in 1900 to 72.4 years in 1975. Of the roughly 2 million deaths annually in the U.S. 37.8% are due to heart disease, 19.5% to cancer, 10.2% to strokes; 4.9% to lung disease (pneumonia, bronchitis and emphysema), 5.3% to accidents, 1.9% to diabetes, 1.7% to cirrhosis of the liver, 1.4% to suicide and 1.1% to homicide. But death statistics give only part of the picture. For every successful suicide, eight others (or 200,000 people) may have made the attempt. For every person who dies of cirrhosis—commonly related to alcoholism and malnutrition—at least 200 and probably 300 people can be classified as alcoholics (10 million Americans). For every accidental death, hundreds are injured, some permanently disabled. Twenty-four million Americans, 11 million of whom receive no federal food stamps, live below the federally defined poverty level, a level that does not support an adequate diet. Vencreal disease has been increasing annually, with nearly 1 million cases of gonorrhea and syphilis reported last year.

Beyond death and disease statistics, there exists a steadily expanding number of the "worried well" and those with minor illnesses. Has life itself become a disease to be cured in the American culture? Some 80% of the doctor's work consists of treating minor complaints and giving reassurance. Common colds, minor injuries, gastrointestinal upsets, back pain, arthritis and psychoneurotic anxiety states account for the vast majority of visits to clinics and doctors' offices. One out of four people is "emotionally tense" and worried about insomnia, fatigue, too much or too little appetite and ability to cope with modern life. At least 10% of the population suffer from some form of mental illness, and one-seventh of these receive some form of psychiatric care. Meanwhile, the figures for longevity are the highest and for infant mortality the lowest in U.S. history, and the gap continues to narrow. We are doing better but feeling worse.

As a people, Americans have been noted for their self-criticism. I would suggest that we give at least equal time to extolling our virtues and triumphs. Let us look at both sides of the coin:

(1) We should be grateful for our medical technology and the countless lives that have been saved because of it. We should gasp at its wild abuse and overuse.

(2) We should be grateful for the markedly improved health of most Americans. We should be horrified by the unmet medical and nutritional needs of nearly 25 million poor people.

(3) We should applaud the development of health insurance mechanisms that have protected the patient from financial disaster. We can decry the fact that health insurance is a misnomer (it is disease insurance) and that so little effort and emphasis have been placed within the insurance system on the maintenance of health.

(4) We can be grateful for the quality of care given in the majority of our 7,000-plus hospitals and 1.5 million beds. We should decry our inability to avoid costly reduplication of services, build more extended-care facilities and low-cost hospitals for the chronically ill, and reduce unnecessary surgery.

(5) We can take great satisfaction that so many Americans have found fruitful work in the health system. We should worry about the low number concerned with environmental health research, health education, visiting nursing and prevention programs.

(6) We can be proud of the quality and quantity of our health-related educational system: 114 medical schools with some 33,000 full-time faculty, 50,000 students and 14,000 Doctors of Medicine graduated annually. We should decry the unbelievable cost of medical education and the precarious state of financing for schools of public health.

(7) We can applaud the activities of the National Institutes of Mental Health. We should decry the meager sums of money available for research in mental illness, which represents the nation's primary public health problem.

The next major advances in the health of the American people will result from the assumption of individual responsibility for one's own health. This will require a change in lifestyle for the majority of Americans. The cost of sloth, gluttony, alcoholic overuse, reckless driving, sexual intemperance and smoking is now a national, not an individual responsibility. These abuses are justified on the ground of individual freedom, but one man's freedom in health is another's shackle in taxes and insurance premiums.

In the 17th and 18th centuries, moral and astrological factors were supplanted by theories that attributed disease to mental states, heredity, unknown poisons, environmental factors ("airs and waters"), contagion by mysterious poisons ("miasmata") and infection by animalcules ("germs" described by the early microscopists). With Pasteur's work in the late 19th century, a unitary theory of disease developed as a natural concomitant to the germ theory of disease: single organism, single disease, single cause. With further research, we have come full circle to colonial beliefs. It is now realized that there are multiple causes of disease, involving varying combinations of genetic factors, environmental factors (levels of stress, pollutants, germs and parasites) and behavioral factors (rest, smoking, exercise, diet, alcohol and hygiene).

When all is said and done, death and disease are inevitable, and as we eradicate one scourge, another will take its place. Ethical and moral concerns will have to play an increasing role in guiding us through lives of quality. These concerns will be matched with a typically American hardheaded pragmatism that tells us health care is only one element in the quality-of-life equation and the other elements, which depend on national will and individual responsibility, are equally important, if not more so.

THE AIR RESEARCH AND TRAINING PROGRAMS, CLEAN AIR ACT AMENDMENTS

Mr. BENTSEN. Mr. President, I had originally intended to offer an amendmnt to insure that adequate funding would be provided for two relatively unheralded but nevertheless extremely important program authorized by the 1970 Clean Air Act. These programs, which help to fund State air research and training efforts, have been of great assistance to a number of State air pollution control agencies during the past 5 years, and I believe a continued commitment of Federal assistance for them is fully warranted.

In 1970, Congress assigned primary responsibility for enforcing the act to the States. They were to devise their own implementation plans for attaining the national air quality standards, and following EPA's approval, they were to enforce them. This year's amendments both clarify and expand these enforcement responsibilities.

As the States have prepared and begun