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The views expressed are those of the Chairman and do not necessarily reflect those of the Federal Trade Commission or the other Commissioners.

The organizers of this conference have followed a hallowed tradition by speculating, in the conference title, about the possibility of a "sea change" in antitrust policy. Time will, as always, tell. But our historical experience suggests that the currents have been remarkably consistent over the decades, changing with the reassuring regularity of the tides. The enforcement policies the Commission has been following for the past five years have been thoroughly mainstream and are likely to continue to be so. There are few signs of currents strong enough to shift us onto headings so new that they remain completely uncharted even after seventy-eight years of exploration.[1]

The Commission was charged in 1914 with the task of protecting the interests of consumers by preventing unfair methods of competition. From the outset, the Commission was expected to apply expertise about commercial practices and insights from economics, and to take advantage of the flexibility of administrative, as contrasted with judicial, processes. The theme of my talk today will be how the general principles announced in our enabling statute are adapted to new situations through those flexible procedures. One obvious object of this process, because it is a matter of intense current interest, is

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health care and proposals for health care reform. But I will also mention many of the other things that the Commission has been doing lately, in part to illustrate that what we do in health care is pretty much the same thing we do in other settings.

The skeptical listener may now rise to object: Doesn't the recent announcement of special guides for antitrust enforcement in health care demonstrate just the opposite, that health care cannot be treated just like everything else, but that it requires special rules, if indeed competition rules apply there at all? Before I explain why the answer to that is "no", let me illustrate the themes, of continuity in general principle and flexibility in particular applications, with another line of recent cases.

Over the last year, the Commission has issued three consent orders against what can be called "invitations to collude."[2] These cases exemplify the unique role of Section 5 of the FTC Act and the Commission's authority to apply that law.

First, substantive law. One of the Commission's tasks is determining what kinds of conduct are covered by Section 5's

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[2] Quality Trailer Products, Dkt. C-3403 (Nov. 5, 1992); YKK (USA), Dkt. C-3445 (March 25, 1993; Commissioner Azcuenaga dissenting); AE Clevite, Dkt. C-3429 (March 24, 1993; Commissioner Azcuenaga dissenting).

grand but general terms, "unfair methods of competition" and "unfair or deceptive acts or practices." Here is the kind of conduct described in the complaints in these cases: A company official tells its competitor, in negotiations over some other deal, that there is "plenty of room in the industry for both firms," so there is "no need for the two companies to compete on price." Or, a company representative complains to a competitor about a tactic that amounts to a price cut, and then suggests that they both discontinue it. Or, an official complains that its competitor's lower prices are "ruining the market," and then, in case the competitor did not get the point, faxes its price list to the competitor.

Technically, the conduct that these three orders prevent does not appear to violate the Sherman Act. The complaints do not allege that the other party to the communication signalled assent, either by word or deed. That is, the complaints do not claim that there was a "combination," as is required by Section 1. Nor do they allege that there was a dangerous probability of achieving monopoly, as is required under Section 2. To be sure, two of the complaints describe very high concentration. In one of these cases, the two firms involved shared over 80 percent of sales; in the other, well over 90 percent. The conduct these complaints describe could well have led to a significant reduction of competition, with no offsetting benefit--except, of course, to the parties themselves.

It is significant that these cases were concluded with consent orders under Section 5 of the FTC Act, and not with Sherman Act judgments by a federal court. The Commission's processes and remedies are particularly useful in cases like these, ones that fill gaps in the doctrines developed under the other antitrust laws. This is exactly what Congress contemplated when it established the Commission in 1914: that it would apply Section 5 to conduct that was not obviously a violation of the Sherman or Clayton Acts, and that its orders applying Section 5 would be prospective, not punitive. Congress rejected a proposal, promoted by Senator Robert La Follette--from my home state of Wisconsin--and others, that would have given the Commission much broader powers. La Follette would have made the Commission into a general trade regulation court empowered to assess damages for all kinds of claims about monopoly and trade restraint--not to mention handle all the work now done by the International Trade Commission, and then some. But that is another story. Instead, the Commission was empowered only to issue orders to cease and desist, and not to assess damages or levy criminal penalties.[3] As a result, the Commission's traditional processes are particularly appropriate for exploring

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[3] Since 1914, Section 13 has been added to the FTC Act, empowering the Commission to seek a wider range of equitable relief through suits in federal courts. Under this authority, the Commission has sought--and obtained--restitution from infant formula makers charged with refraining from bidding against each other for a federal-state nutrition assistance program.

and developing new applications of competition principles and applying them to new settings.

In the Commission's early days, the courts might have prevented the Commission from addressing tactics such as these invitations to collude. The Commission was to look out for the interests of consumers, but only indirectly; not by preventing conduct that harmed consumers, but by preventing unfair methods of competition, in the faith consumers would ultimately benefit. This meant that Commission actions had to target conduct that put particular competitors at an unfair disadvantage in the marketplace. If all the competitors were doing the same thing, or if all of them benefited from the conduct at issue, then it was difficult to claim that anyone was unfairly disadvantaged--except, of course, the consumer. The famous Raladam case in 1931 crystallized this anomalous limitation on the Commission's authority.[4] That old case illustrates the close relationship between the Commission's competition and consumer protection missions, and it will bridge nicely into my discussion of their complementary application in health care settings. It also shows how some kinds of cases will be with us forever.

The Commission was trying to stop a thriving, but fraudulent and potentially dangerous, quack diet business. Does this sound

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[4] FTC v. Raladam, 283 U.S. 643 (1931).

familiar? The product was a thyroid and iodine concoction called Marmola, peddled by a veteran con artist who had already been forced by several previous convictions to stop using the mails to sell virility nostrums.[5] The Commission sued him in 1928, claiming that his advertisements for Marmola as "safe and effective" were unsupported. But the Supreme Court found a flaw in the Commission's case: the Commission had not alleged, and the record did not show, that any legitimate competitors had been harmed by this falsehood. Even Justice Brandeis, who as a consumer advocate had vigorously promoted the creation of the FTC twenty years before, did not disagree with that reasoning. The Court quipped that the FTC Act was not intended to protect one knave from the unfair competition of another. Of greater interest, perhaps, the Court observed that doctors, who would counsel against taking Marmola without their advice, would not count as competitors, because medical professionals were not, after all, involved in "trade."[6]

In response to the decision, Commission lawyers started adding boilerplate complaint allegations that whatever practice was being challenged had diverted trade from more honest and deserving competitors. The Wheeler-Lea Act, passed in 1938, corrected the technical problem by authorizing the FTC to prevent

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[5] See Lamb, American Chamber of Horrors 5 (1936).

[6] 283 U.S. at 653.

"unfair or deceptive acts or practices," and thus to develop a law enforcement mission aimed directly at consumer protection. That year also saw the strengthening of the food and drug laws. As a result, the FDA could seize products like Marmola, and the FTC could go to federal court to block false advertising for drug products. Also in 1938, the Court's musing in Raladam about how professionals are not involved in ordinary competition was called into question. For that was the year that Thurman Arnold's Antitrust Division obtained an indictment against the American Medical Association for attempting to prevent the establishment of what we would now call a managed care organization. The Supreme Court upheld the subsequent conviction in 1943.

It was with that same association and, in part, that same issue that the FTC launched the modern era of health care antitrust some thirty years later. Since the Commission's AMA case was undertaken,[7] nearly twenty years' worth of government enforcement actions and private lawsuits have applied antitrust principles to this industry. Federal antitrust enforcement has been instrumental in enabling novel, potentially cost-effective means of delivering services to enter the marketplace. Antitrust enforcement, and the FTC's critical consumer protection role in conjunction with it, are consistent with the various reform

[7] 94 FTC 701 (1979; complaint issued December 19, 1975).

proposals that rely on healthy market competition and informed consumer choice.

Health care issues have demonstrated perhaps better than any others the close and complementary relationship between the Commission's competition and consumer protection interests. The seminal health care antitrust case of the modern era, the Commission's AMA decision, illustrates that relationship perfectly: rejecting the argument that competition in health care was itself contrary to the public interest, the Commission held that the Association's restraints on advertising, patient solicitation, and alternative forms of practice violated both the competition and the consumer protection aspects of Section 5.[8] But, in recognition of how consumer protection principles promote healthy competition, the Commission's order banning the restraints permitted the AMA to continue to monitor advertising for the purpose of preventing deception.[9]

The Commission continues to bring cases aimed at efforts by groups of competing health care providers to restrict competition either by adopting anticompetitive rules or by engaging in coercive action. Just last summer, the Commission issued a Part III complaint challenging the alleged efforts of a private

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[8] Id. at 1010.

[9] Id. at 1030.

association of health care professionals to restrain non-deceptive advertising about the price and quality of services.[10] Consent orders concerning similar conduct have been issued in the last year to the American Psychological Association[11] and the National Association of Social Workers.[12]

The issues in these cases are not unique to health care, of course. Over the years the Commission has issued orders and rules against restraints on non-deceptive price advertising for scores of businesses. This summer the Commission issued consent orders addressed to similar restraints by two associations of engineers.[13] The Professional Engineers order deals with restraints on advertising, while the Soil Engineers order addresses a "peer review" process to discipline members about their fees, pricing, and bidding, and exchanging information about intentions not to bid, that is, not to compete.

In addition to dealing with constraints on advertising, the Psychologists and Social Workers orders deal with constraints on

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[10] California Dental Association, Dkt. 9259 (complaint issued July 9, 1993).

[11] Dkt. C-3406 (Dec. 24, 1992; Commissioner Azcuenaga dissenting in part).

[12] Dkt. C-3416 (March 16, 1993; Commissioner Starek dissenting).

[13] ASFE (Soil Engineers), Dkt. C-3430 (June 18, 1993); National Society of Professional Engineers, Dkt. C-3454 (August 10, 1993; Commissioner Starek dissenting).

referral fees and services. The orders prohibit rules against making payments to referral services, but permit rules requiring disclosure that a referral fee is being paid. The orders thus recognize that the use of referral fee arrangements implicates competing interests. On the one hand, by allowing the use of referral services, the orders permit the use of a potentially efficient way of matching supply to demand, that is, practitioners to patients. On the other, by allowing a rule requiring disclosure when a referral fee is being paid, the orders may help ensure that consumers have information needed to decide whether the practitioner is giving the kind of advice and service they expect.

A related issue is the practice of "self-referral" of patients to ancillary ventures owned by the referring physicians. Self-referral raises a number of legal and ethical issues that other regulatory agencies, the Congress, state legislatures, and professional organizations such as the AMA are wrestling with. From an antitrust perspective, the concern is not self-referral in itself. The antitrust concern is with the creation or enhancement of market power in the market for the ancillary service, through the aggregation of competing health care professionals who have the power to refer patients to the entity providing the ancillary service.

Earlier this week, the Commission announced action in two cases that apply these principles. The Commission has accepted for public comment two consent agreements involving joint ventures that provide oxygen delivery systems to patients at home.[14] These home oxygen systems are almost invariably prescribed by, or under the direction of, a lung specialist, or pulmonologist. According to the Commission's complaints, roughly 60 percent of the pulmonologists in the relevant geographic markets were recruited as investors in these partnership joint ventures. The complaints allege that, by bringing together so many of the physicians who could influence patient choice, the partnerships obtained market power, created barriers to entry, and restrained competition in the market for home oxygen systems.

The consent orders accompanying the Home Oxygen complaints require divestiture to reduce the percentage of pulmonologists affiliated with the partnership in their geographic market to 25 percent. Such a structural remedy is appropriate where the competitive harm arises from a structural cause, the aggregation of such a large share of the physicians having the power to steer patients to an ancillary venture. The orders' focus on structural relief also recognizes the fact that, although the

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[14] Home Oxygen & Medical Equipment Company, File No. 901-0109, and Homecare Oxygen & Medical Equipment Company, File No. 911-0020 (consent orders issued for public comment November 2, 1993; Commissioner Azcuenaga concurring with separate statement; Commissioner Starek dissenting).

conduct--the physicians' ability to influence patients' choice of ancillary suppliers through self-referral or other means--is an important market factor underlying the theory of competitive harm, that conduct does not violate the antitrust laws in and of itself. Thus the orders do not prohibit self-referral or other means of influencing patient choice.[15]

Like the invitation to collude cases, the Home Oxygen cases demonstrate the use of Section 5 of the FTC Act to apply general antitrust principles to novel situations. Although these are the first cases the Commission has ever brought against self-referring medical joint ventures, the basic principles being applied here are entirely traditional. Other Commission investigations are continuing involving similar joint ventures to provide ancillary services. At least in the absence of more sweeping legislation against self-referral generally, cases like these may be an important part of the Commission's efforts to preserve competition, and reduce costs, in health care markets.

The recently announced enforcement policy statements about the application of antitrust principles to health care situations confirm that the policies being applied there are mainstream

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[15] Self-referral may be regulated or prohibited by other state or federal laws and regulations, however. See, e.g., the Medicare Anti-Kickback Statute, Section 1128B(b) of the Social Security Act, 42 U.S.C. 1320a-7b(b), making it a felony to make certain kinds of payments intended to induce the referral of business payable under Medicare or Medicaid.

antitrust law. These statements have been widely and accurately understood to be restatements of current practices. A brief survey of their highlights shows how constructive cooperation is permitted, even encouraged, within a framework of a competitive marketplace for access to services. And a comparison with our actions in other settings will show how the policies announced for health care are consistent with those that apply generally.

The shortest of the statements is about technology joint ventures. Neither the FTC nor the Department of Justice has ever challenged a joint venture to acquire and operate expensive, high-technology medical equipment. If the joint venture is necessary to provide the service because the individual parties could not afford to do it independently, of course antitrust law will not prevent it. The statement, by setting out an explicit "safety zone" for this case, provides reassurance to those who might, despite our enforcement record, still doubt our intentions. Even if the parties might be able to acquire and operate the equipment on their own, application of the usual rule of reason principles may reveal that joint activity would be efficient and would not, on balance, injure competition. The statement sets out the considerations, which are familiar to antitrust practitioners from other contexts. It goes further, to provide detailed hypothetical examples that illustrate how such a venture would be analyzed and how it could be constructed without

raising antitrust problems. It shows how antitrust principles do not condemn the achievement of pro-competitive efficiencies.

The statements' treatment of joint purchasing arrangements for other kinds of products and services is similar. Joint activity to achieve efficiencies in procurement is generally permissible. Antitrust becomes concerned only when the scale of the activity or other features of the arrangement threaten to reduce competition. To make the criteria concrete, the statement sets out numerical thresholds: we will not be concerned, absent extraordinary circumstances, if the purchases by the participants in the joint arrangement amount to less than 35 percent of the sales of the purchased item in the relevant market, and the costs of the purchases account for less than 20 percent of each participant's revenues. These thresholds are consistent with prior practice and announced enforcement policy. And here again, even where these criteria are not met, the statement makes clear that joint purchasing arrangements may still be acceptable, under a rule of reason analysis of their likely net effect on competition.

The two statements about information sharing set out ways that professionals or hospitals can participate in information sharing arrangements without using them to eliminate competition. The safety zone for physicians permits unlimited sharing of information about outcomes, that is, about medical procedures and

the effectiveness of treatment. And it permits collective action to develop suggested practice parameters or standards for patient management. The safety zone for hospitals makes it clear that the law has no problem with participation in third-party surveys of historical information about prices and personnel costs, as long as the surveys meet certain requirements that the guideline spells out. Antitrust law will not stand in the way of efforts to improve the quality of care or the efficiency with which care is delivered.

But the safety zones are closed to the exchange of information about future pricing intentions or to attempts to coerce action by threatening boycotts. There is ample reason for drawing those limits. Among our earliest modern-era health care cases were orders against concerted efforts to block cost-containment efforts. Just six weeks ago, the Commission issued an administrative complaint alleging a boycott aimed at a prescription drug program's effort to reduce reimbursement rates,[16] a boycott that could have led to higher costs for consumers.

Although we still encounter providers joining together to thwart cost-containment efforts and suppress competition, we are also seeing efforts to develop more cost-effective "integrated

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[16] Maryland Pharmacists Assn., Dkt. No. 9262 (complaint issued September 29, 1993).

delivery systems" designed to compete better with other providers and meet the needs of third-party payers more effectively. This brings me to the longest of the recently issued policy statements, and the one most directly relevant to the various proposals to reform the health care system. This is the statement of enforcement policy for physician network joint ventures.

The problem is drawing the line between a pro-competitive joint venture and an anticompetitive combination. Obviously, the decision cannot turn on the label. When a supposed joint venture amounts to an agreement to divide up a market and eliminate competition, the Commission will treat it like the conspiracy it is. Last spring, the Commission issued an order against an entity that called itself a joint venture to provide school bus transportation, but was in fact, the complaint alleged, a device through which its members would allocate areas of service and avoid bidding against each other.[17] Enforcement action has been taken in the past against groups of health care professionals that have called themselves "individual practice associations" or something similar, we alleged, but that in substance were merely combinations to coerce third party payers to accept their price dema

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[17] B&J School Bus Services, Inc., Dkt. No. 3425 (April 26, 1993; Commissioner Azcuenaga dissenting in part).

[18] Southbank IPA, Inc., Dkt. C-3355 (consent order, January 24, 1992); Preferred Physicians, Inc., 110 F.T.C. 157 (consent order, 1988).

The policy statement sets out certain conditions under which the law will have no problem if providers band together. Two features are important. First, the parties must be creating a real joint venture, not just a bargaining group. This means they must shoulder substantial financial risk. The statement sets out two examples of risk sharing that fall inside the safety zone: willingness to be compensated by a capitation plan or to tie compensation to meeting cost-containment goals. The two methods of risk sharing that the guide describes are not necessarily the only ones that could be found acceptable.

Second, the venture must not represent such a large share of the professionals in the market that competition for professional services is impaired. The safety zone boundary is set at 20 percent, but the statement sets out circumstances under which participation in such a network venture would be acceptable even if that threshold were exceeded. The statement includes examples to demonstrate how rule of reason principles would permit construction of such network ventures even in relatively small communities without raising antitrust problems.

Thus, the policy statement on physician joint ventures clarifies that the antitrust laws allow room for physicians to engage in cooperative efforts that will help third-party payers purchase better health care for their subscribers or reduce the costs of providing that care. Physicians have already taken

advantage of this latitude to form integrated delivery systems that potentially offer payers a "win-win" solution--a cost-effective method of delivering high-quality health care services that benefits providers and consumers alike.

But the policy statement does not retreat from the long-standing agency position, supported by court decisions, that collaborations that merely confer clout by combining their members' economic leverage, without offering lower-cost or higher-quality health care through meaningful integration, raise serious antitrust questions.

Finally, there is a policy statement concerning hospital mergers. The antitrust agencies have developed a unified, coherent analytical approach to mergers and acquisitions over the last decade. The standards of our Merger Guidelines are applied when deciding about enforcement actions in all kinds of industries. In the last year, the FTC obtained a preliminary injunction blocking a proposed merger that would have eliminated bidding competition for the Army's procurement of tank ammunition; that case was later settled with an FTC consent order.[19] And the Commission recently authorized the staff to seek an injunction against a proposed acquisition that, we alleged, would have reduced competition in the market for leased

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[19] Alliant Techsystems, Inc. Dkt. 9254 (consent order, March 16, 1993.

boxcars;[20] on learning of that action, the parties abandoned their plans. Other Commission merger actions in the last twelve months have involved silver alloys for filling dental cavities,[21] air fresheners and furniture polishes,[22] low-voltage industrial fuses,[23] coal shipping terminals,[24] non-selective herbicides,[25] acrylic plastics,[26] structural blind rivets,[27] and dehydrated onions.[28] The last case deserves a comment about the relief that was ordered. Merger orders typically call for divestiture of productive assets; for example, the plastics order requires ICI to divest a plant. In the dehydrated onions case, the order goes one step further: rather than plants, the acquiring firm must divest seeds.

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[20] General Electric Co., File No. 931-0110 (September 1993).

[21] Dentsply International, Inc., Dkt. C-3407 (consent order January 6, 1993).

[22] S.C. Johnson & Son, Dkt. No. C-3418 (July 22, 1993).

[23] Cooper Industries, File No. 931-0086 (June 25, 1993; Commissioner Azcuenaga dissenting).

[24] Consol, Inc., Dkt. No. C-3460 (July 1, 1993).

[25] Monsanto Co., Dkt. C-3458 (Sept. 3, 1993).

[26] Imperial Chemical Industries, File No. 921-0099 (July 1, 1993; Commissioner Owen dissenting).

[27] Textron, Dkt. No. 9226 (proposed consent agreement accepted for public comment, October 28, 1993).

[28] McCormick & Co., Dkt No. C-3468 (October 26, 1993).

The Merger Guidelines' same analytical approach has been applied in investigations of hospital mergers. The statement about hospital mergers translates that analysis into readily applied criteria aimed at this particular industry. We are aware of publicly voiced concerns about whether antitrust laws should be applied to consolidations in this industry, which is facing rapid change and fundamental restructuring. We have not tired of pointing out how rarely hospital mergers have been challenged. Over the last half decade, there have been hundreds of such combinations; the federal enforcement agencies have challenged just eight of them. The last year witnessed substantial consolidation, as nationwide chains, among others, have restructured their operations. Let me review some of our actions here during the last year, to demonstrate the flexibility and sensitivity of our responses to the changes in this industry.

The Commission dealt twice with efforts by a nationwide hospital chain, Columbia Hospital Corporation, to acquire hospitals in Florida. In each case, the Commission acted because it had reason to believe that the challenged acquisitions would likely have caused a substantial reduction in competition and consumer choice. The Commission obtained a court injunction blocking Columbia's proposed acquisition of a hospital in southwest Florida, in a market where it already had a similar-sized facility. Later, in conjunction with Columbia's acquisition of another nationwide hospital chain, Galen Health

Care Corporation, Columbia agreed to a consent order requiring it to divest a hospital in central Florida. In that $3.2 billion transaction, bringing together 90 facilities all over the country, the Commission challenged only this one aspect.

Not only the hospital industry, but all aspects of the health care industry are contemplating major changes in their structure and operation. Many of the kinds of changes that reform proposals would accelerate are already underway. The groundwork for those changes was laid by a long series of applications of standard antitrust principles to this industry. Most of the reform proposals presume, indeed depend on, marketplace competition and informed consumer choice. To that extent, they would not call for significant relaxation of existing antitrust rules about mergers, joint ventures, or other joint activity.

There are, to be sure, some technical issues of antitrust doctrine that may require attention. The collection of statutory changes may include modifications to the McCarran-Ferguson Act, changing how antitrust applies to the business of insurance. There might also be issues under the state action doctrine. But these issues are familiar. The two basic state action principles that apply to private parties' actions, of clear articulation and active supervision, have been expounded in dozens of cases in health care and other settings. To the extent there was

uncertainty about how much "active supervision" is necessary, that uncertainty has been significantly resolved by the Commission's decision in Ticor, and by the Supreme Court's affirmance of it.

But I see no need for wholesale antitrust exemptions or changes to the basic antitrust statutes to accommodate federal and state health care reform efforts. In any market-based system of delivering health care, antitrust enforcement will be important to maintaining a competitive market environment, so that when consumers and health plans go shopping for health care services, they will have a reasonable range of alternatives to choose from. My colleague, Commissioner Yao, gave a thoughtful speech a few months ago on the general topic of applying antitrust principles in the new environment of more widespread "managed care" institutions, which I commend to your attention. He noted how, in this environment, elements of competition are being simplified in order to make services more widely available and to make it easier for consumers to compare and decide, and the number of participants may decline in order to achieve efficiencies. But he warned that those trends could also make it easier for health care providers to reach anticompetitive market outcomes. If that is the case, then this is emphatically not the right time to declare broad exemptions from antitrust oversight.

Adapting antitrust principles to health care settings--which also involves adapting health care institutions to antitrust principles--has called forth flexibility and imagination in designing and applying appropriate procedures. The policy statements are an example of that kind of flexibility. There are precedents, of course, in other pronouncements that are not formally binding but are sometimes treated, by those affected, as if they stated legal rules. The health care policy statements are the latest example, but the Commission's "green" guides about environmental marketing and the agencies' Merger Guidelines are others.

The demand for some kind of authoritative guidance short of formal rules and litigation is long-standing. The Commission was created with the power to issue formal, binding orders, but with the expectation that it would also dispense a great deal of informal advice. Misunderstandings and controversies about how much it was supposed to do of one, and how much of the other, began the day it opened its doors. One of the Commission's first acts in early 1915 was to call in Louis Brandeis to discuss how the Commission should respond to requests for advice about how to comply with the Sherman and Clayton Acts. Businesses recognized what I described at the start of my talk, that the Commission's administrative processes did not expose them to criminal penalties or private damages suits. In fact, they were hoping that, by relying on Commission advice, they could avoid those

penalties altogether. Brandeis, speaking as a veteran litigator, was dubious. He cautioned against giving advisory opinions, because the Commission could never be sure it knew all the critical facts.

In the next few years, businesses that had expected to receive guidance from the Commission were outraged when they received subpoenas and complaints instead. Thus, a decade--and a couple of elections--after Brandeis told the Commissioners to stay out of the advice business, the Commission was in it with a vengeance, sponsoring trade practice conferences and other ways of helping businesses identify their compliance obligations through informal, nonlitigated procedures. To the consternation of the Progressives who had originally backed the Wilson Administration's FTC, the Coolidge FTC did not even publicize the names of respondents or the conduct they were charged with. In the last few decades, law enforcement action has again predominated, but that period has also seen many rulemaking proceedings and three editions of Merger Guidelines.

The processes of formal litigation and more or less formal advice, guidance, and rulemaking are complementary, of course. Issuance of enforcement policy guidance may look to many observers like rulemaking. But the product, although intended to embody legal and policy consensus, lacks the binding force of formal rules. Rather, it represents the accumulated experience

of litigation and predictions about its outcome in the future. And resolution of controversies through consent orders, even though technically litigation, often represents a similar process, that is, a ratification of a consensus viewpoint about basic legal principles, implemented at lower cost in time and resources (and other legal exposure) than protracted litigation.

The statements about health care industry enforcement policy announce that the Commission is again ignoring Louis Brandeis's advice to the Commission, and is undertaking to give advice about compliance with the law. We and the Department of Justice have committed ourselves to respond by a date certain--within 90 days or 120 days, depending on the nature of the request, from when all the necessary information is received--to requests for advisory opinions on health care problems. Here again, we are taking this step to make sure that the industry has no legitimate cause for concern about the supposed uncertainty of how the rules of competition will apply to it.

The policy statements and our advice about compliance with the law are intended to allay concerns that antitrust enforcement could impair the delivery of health care services. They should also allay fears that antitrust would be an obstacle to the implementation of proposed reforms to the health care system. Whatever is done in this industry to promote other goals, such as universal health care service, will be built on the competitive

foundation that underpins our entire economy, to the extent we rely on market institutions to satisfy consumer needs and desires. I believe that history, both ancient and modern, shows that the Commission, and indeed antitrust law and procedure generally, is fully capable of adapting its procedures and substantive rules to changing conditions and novel, complex industry situations.