the 12 percent factor plus duties, the foreign bid was still low. But, an evaluation using the 50 percent differential resulted in the domestic bidder being low and receiving the contract. After considering discount and freight, this procurement cost almost $107,000 more than it would have from the foreign source.

Because of the above influences neither DPSC nor VA normally make any special effort to develop foreign sources for their drug requirement even though prices of drugs of foreign origin, as a general rule, are lower than domestic prices. Efforts to obtain bids from foreign sources are limited to the actions normally taken to obtain bids from any source, that is, solicitations are sent to the few foreign firms on the bidders list at the time they are sent to other potential suppliers and the proposed procurements are announced in the Commerce Business Daily. The VA also sends copies of its solicitations for items to be procured competitively to publishers of a number of marketing publications.

In November 1971 VA wrote to several Canadian firms inquiring whether they marketed three specific drug items in the United States. Four of the eight replies said that the firm did not yet have the necessary NDA approval and the others said that they did not market or manufacture the items.

Appendix IV shows the drug items procured from foreign firms in the years 1968 through 1971 by DPSC and VA.[1]

I would like to turn now to the policies and regulations and practices which relate to medicaid and medicare.

The current HEW policy for the payment for prescription drugs under the medicaid program does not require uniform procedures and practices to be followed by the States. Also, the use of a formulary is optional, but where one is used standards for quality, safety, and effectiveness must be set and supervised by professionals. The Social and Rehabilitation Service is responsible for administering the medicaid program.

The formulary system should be broad enough to enable physicians and pharmacists to select high quality drugs of recognized therapeutic value for the treatment of any medical situation. Approximately 20 States have attempted to control the cost of drugs in their medicaid programs through the use of formularies. Attempts have also been made by the States to limit certain drugs in their formularies to generic names.

In November 1970 we reported to the Congress that significant savings could be available to the States and the Federal Government if physicians were to prescribe lower-priced, chemically equivalent drugs instead of higher-priced brand name drugs. We pointed out that the HEW Task Force on Prescription Drugs reported in December 1968 that of the 409 brand name drugs most frequently prescribed for elderly persons in 1966, chemical equivalents for 63 of these were available at lower costs. These 63 drugs accounted for about one-fourth of the prescriptions for the 409 drugs, and the task force computed that prescribing the lower cost chemical equivalents would have resulted in annual savings of $41.4 million.

The HEW task force reported also that physicians were not always aware of low-cost, chemically equivalent drugs produced by competing manufacturers or were reluctant to prescribe such drugs until their safety and effectiveness had been proven.

[1] See p. 8831.