Dr. WELLS. In terms of actual quantitative success, I am not sure that we have—do we, Roland, figures on that as to what extent we have been able to get physicians to take alternatives? Is that tabulated in here?

Mr. HARDING. Not yet.

Dr. WELLS. I do not think we have any specific figures that we can give you on that. We know that it has had some degree of success. But to give it to you quantitatively, I could not do it.

Dr. LEE. Mr. Chairman, we could not possibly attribute to that statement alone any quantitative degree, because there have been six different releases in the last 18 months to our various stations reminding them of these various things and indicating that these restrictions should be followed.

Mr. GORDON. At the bottom of page 4, you state:

> On May 25, 1972, we distributed to all VA field stations copies of the current listing of FDA classifications of drug effectiveness. We feel that these actions have almost eliminated the procurement of ineffective drugs, even though FDA still permits their manufacture and marketing.

How about under your reimbursement program, where you have fee physicians? Does this apply to the "possibly effective" drugs also?

Mr. HARDING. Yes. That has practically been closed off to the hometown program but we do have some fee physicians writing for particular drugs that are on the ineffective list. We are trying to get this information out to them. What we have done is draw up a paper, a professional services letter, which we have forwarded to all of our field stations with a concise list extracted from this FDA listing and we have told the field stations they can take this list and send it out to all their fee physicians, again bringing it to their attention. The fee physician is still independent. As you know, in the VA, after that law was changed, we don't have the control of the fee physician we used to have. Now any veteran can go to any doctor he wishes and we may not know a particular doctor is going to treat a veteran until a prescription comes in or a fee comes in to be paid for. At that time, we hurry and get out a list to him.

If one of our pharmacies receive a prescription written by a fee physician for a drug that has been classified ineffective or possibly effective, we call the physician, and ask if we can use a drug from our formulary that has a higher classification from the one he is prescribing. However, if the patient takes the prescription to the local pharmacy and has it filled and sends the bill to us for payment, we have to pay for the medication. In the meantime, we notify the physician of our desire to pay for only the most effective drugs available.

Mr. GORDON. Why can't you issue to the physicians who are under contract to you and to the pharmacies a list of all the drugs for which you will reimburse, rather than do it in a negative way. Why can't you say: "Here is a list of drugs; we will pay for these drugs and no other ones"?

Mr. HARDING. Sir, we do not even know for sure who this physician is going to be until we receive the prescription from him.

Dr. LEE. To place this into perspective, may I indicate for present consideration, although it is in the record, that there are 100,000 of these fee basis physicians scattered throughout the country. Hence it is a question of volume as well as a question of attempt to communicate.