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.

Medicare

Regulations for part A of Medicare set forth two basic requirements that must be met in order for a drug or biological to be included as a covered hospital service. It must (1) represent a cost to the institution in rendering service to the beneficiary, and (2) either be included, or approved for inclusion, in the USP, the NF, the U.S. Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated), or approved by the pharmacy and drug therapeutics committee (or equivalent) of the medical staff of the hospital for use in the hospital. There are no Medicare regulations concerning the use of generic versus brand-name drugs.