remuneration is dissociated from the cost of the drug product dispensed. It is not difficult to understand why pharmacists who use the markup system are complacent about brand name prescribing.

APhA for the past several years has been trying to educate pharmacists on the advantages that the professional fee system holds for both the patient and the prescriber as well as the pharmacist. We think the fee system also serves the best interest of the pharmaceutical industry.

Briefly stated, the cost of the drug to the pharmacist has absolutely no bearing on the professional functions he performs in dispensing a prescription order. If he applies a 40-percent markup on an $18 drug cost, he must add $12; on a $1.80 drug cost he must add $1.20. The professional service rendered in each case is the same.

There are some pharmacists who oppose price discrimination by drug manufacturers but who support the inequitable markup system of prescription pricing. The inherent inequity of the markup system is that patients who require the more expensive drug products must subsidize patients who require the low-cost medications and this results in price discrimination among patients.

One of the most frequently voiced objections to the professional fee is that it does not take into consideration elementary cost accounting factors. Let's look at this myth.

A recently reported cost accounting study revealed the U.S. average cost of dispensing a prescription order is $1.69. If we add $0.31 average net profit per prescription, we would have $2 as the total which would have to be added to the actual cost of the drug product to recover all of the operating costs and yield an 8.5-percent net profit on the 1966 U.S. average prescription charge of $3.60.

According to the 1966 Lilly Digest, the average number of prescriptions dispensed was 19,962 per pharmacy reported in its study. Again using the $2 figure, the total amount of dollars required to pay for operating expenses and yield an 8.5-percent net profit would be $39,924. Under the markup system, some prescriptions would contribute as little as $0.25 or $0.50, while others might contribute as much as $5 or $10 to yield the $39,924 gross margin. Under the professional fee system, each prescription would contribute $2—the average fee required to provide professional service in this hypothetical example.

If one patient requires a drug which costs the pharmacist $12, we see no reason why he should be charged $27, while another patient who requires a drug which costs the pharmacist $1.20 should be charged only $2.70. Under the markup system, one patient is overcharged $13 to recover the $0.50 undercharge to 26 patients. Isn't it more equitable for the patient who needs the $12 drug to pay $14 for his prescription while the 26 patients who need the $1.20 drug each pay $3.20 for their prescriptions?

The opponents of the markup system will quickly point out that the inventory investment in a $12 drug is $10.80 more than in a $1.20 drug while completely ignoring that the $1.50 markup added to the $1.20 cost of the drug fails to even cover the bare operating expenses. The point is that in the end each system will produce the same number of dollars for a specific pharmacy when the professional fee established by that pharmacy is equated to the gross margin of the average prescription charge of that pharmacy.