the private patient and a substantial subsidization of the sometimes unrealistic prices available to other practitioners, hospitals, governments and similar agencies. This situation is not appreciated by the uninformed. It is certainly not condoned by Pharmacy and we repeat our often stated, firm belief that this gap should not exist.

7.9 *Prescription Pricing Methods*: Generally speaking, two pricing methods are followed: (i) that involving a basic percentage mark-up based on retail list price plus a minimal professional fee of up to 75 cents related to the multiplicity of extra responsibilities and legislative requirements which are not part of a commercial transaction; and (ii) a cost-plus-professional fee concept of pricing. The latter is proving popular as it becomes better understood. It permits public assessment of the service being rendered as separate from variations in the cost of ingredients, and is used in various contractual agreements with paying agencies.

7.10 *Price Increases*: The chart presented earlier in this Brief illustrates the increase in the average price of a prescription that has been experienced over the years. These increases are, of course, expressed in terms of the inflated dollar and are very realistically influenced by (1) inflation and consumer price index; (2) inflation and wage rates, both in the general economy and relative to remuneration of personel; (3) the increased quantity of doses per prescription; (4) increased cost of ingredients with specific drug therapy available today as opposed to symptomatic treatment of just two decades ago, and with federal sales tax on drugs having increased from 8 per cent to 11 per cent between 1951 and 1958; (5) greater use of drugs for chronic, ambulatory treatment; (6) greater demand arising from the knowledge that today's drugs can quickly return the patient to full health. (A graph illustrating the increase in the the average prescription price from 1961 to 1965 is shown on page 12.)

7.11 *Retail Subsidization of Prescribed Drugs:* Previously in this Brief, evidence is presented to illustrate the manner in which the sale of non-drug items does, in effect, subsidize the financial ability of the retail pharmacist to provide a comprehensive pharmaceutical service in conveniently located community facilities.

7.12 Elsewhere, too, attention is drawn to the multi-pricing policies of manufacturers which force the retail pharmacist to purchase his drug supplies at prices which far exceed those paid for the same quality, strength and quantity by others who may legally purchase them—more specifically, hospitals and similar institutions, and government agencies. With sales to the latter no longer representing only a minor percentage of the manufacturer's gross, such prices cannot be considered promotional costs and hence, the depressed prices must be subsidized by sales to the normal retail channel.

7.13 In most areas, provincial or municipal agencies finance the health service needs of welfare recipients. Drug services are provided under contractual agreements involving the granting by the retail pharmacist of substantial discounts. Direct losses due to those discounts, and indirect expenses due to the paper work involved as well as the extremely long waiting period for payment must be considered in the gross expenses of the operation of a prescription service.