VOLUME II

P U B L I C H E A R I N G

before the

ASSEMBLY COMMERCE, INDUSTRY AND PROFESSIONS COMMITTEE

on

ASSEMBLY, No. 736
(An Act concerning pharmacists.)
ASSEMBLY, No. 1228
(An Act requiring the posting of a list of retail prices for the 100 most frequently used prescription drugs.)
ASSEMBLY, No. 3263
(An Act concerning the practice of optometry.)
ASSEMBLY, No. 3264
(An Act concerning ophthalmic dispensers and technicians.)
ASSEMBLY, No. 3273
(An Act permitting the advertising of retail prices of prescription drugs.)

Held:
Seton Hall University
School of Law
1095 Raymond Boulevard
Newark, New Jersey
May 23, 1975

COMMITTEE MEMBERS PRESENT:

Assemblyman Byron M. Baer (Chairman)
Assemblywoman Barbara A. Curran
Assemblyman Robert M. Ruane
Assemblyman C. Gus Rys

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ASSEMBLY, No. 736

STATE OF NEW JERSEY

PRE-FILED FOR INTRODUCTION IN THE 1974 SESSION

By Assemblyman BARBOUR

AN ACT concerning the professional conduct and practice of pharmacists and amending R. S. 45:14-12.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. R. S. 45:14-12 is amended to read as follows:

45:14-12. The board may refuse an application for examination or may suspend or revoke the certificate of a registered pharmacist or a registered assistant pharmacist for any of the following causes: When the application or registration is shown to have been obtained by misrepresentation or fraudulent means or when the applicant or registrant is guilty of chronic or persistent inebriety, or has been adjudged guilty of violating any State or Federal law or any law of the District of Columbia or of any territory of the United States relating to the practice of pharmacy, or relating to the dispensing of drugs, or has been convicted of a crime involving moral turpitude, or has impersonated an applicant for registration before the board or has been convicted of knowingly, intentionally or fraudulently adulterating or causing to be adulterated drugs, chemicals or medicinal preparations or has sold or caused to be sold adulterated drugs, chemicals or medicinal preparations knowing, or having reason to know, that same were adulterated, or has procured or attempted to procure registration for another by misrepresentation or fraudulent means, and the board shall refuse an application for examination or suspend or revoke the certificate of a registered pharmacist or a registered assistant pharmacist when the applicant or registrant is shown to be addicted to the use of narcotic drugs, or has been convicted of violating any law of this or any other state or of the United States relating to narcotic drugs or has been adjudicated an incompetent, or is shown

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

to have any abnormal physical or mental condition which threatens the safety of persons to whom said applicant or registrant might sell or dispense prescriptions, drugs, chemicals, medicinal preparations or devices or for whom he might manufacture, prepare or package, or supervise the manufacturing, preparation or packaging of prescriptions, drugs, chemicals, medicinal preparations or devices. In addition, the board may refuse an application for examination or may suspend or revoke the certificate of a registered pharmacist or a registered assistant pharmacist upon proof satisfactory to the board that such registered pharmacist or such registered assistant pharmacist is guilty of grossly unprofessional conduct and the following acts are hereby declared to constitute grossly unprofessional conduct for the purpose of this act:

a. Paying rebates or entering into an agreement for payment of rebates to any physician, dentist or other person for the recommending of the services of any person.

b. The providing or causing to be provided to a physician, dentist, veterinarian or other persons authorized to prescribe, prescription blanks or forms bearing the pharmacist's or pharmacy's name, address or other means of identification.

c. [The promotion, direct or indirect, by any means, in any form and through any media of the prices for prescription drugs and narcotics or fees or for services relating thereto or any reference to the price of said drugs or prescriptions whether specifically or as a percentile of prevailing prices or by the use of the terms "cut rate," "discount," "bargain" or terms of similar connotation; but this shall not include the term nonprofit if such term is used by a nonprofit entity; and this paragraph shall not be construed or apply to have any effect with respect to sales made by pharmacists or pharmacies directly to physicians, dentists, veterinarians or other persons authorized to prescribe, or to hospitals, nursing homes, governmental agencies, or other institutions licensed under Title 30 of the Revised Statutes, as amended or to the advertising or issuance of trading stamps and similar devices in connection with the sale of said prescription drugs and narcotics.] *The use of the terms "cut rate," "discount," "bargain," or terms of similar connotation in connection with the promotion, direct or indirect, by any means, in any form or through any media, of the prices for prescription drugs and narcotics or fees or for services relating thereto.*

d. The claiming of professional superiority in the compounding or filling of prescriptions or in any manner implying professional

superiority which may reduce public confidence in the ability, character or integrity of other pharmacists.

e. Fostering the interest of one group of patients at the expense of another which compromises the quality or extent of professional services or facilities made available.

f. The distribution of premiums or rebates of any kind whatever in connection with the sale of drugs and medications provided, however, that trading stamps and similar devices shall not be considered to be rebates for the purposes of this chapter and provided further that discounts, premiums and rebates may be provided in connection with the sale of drugs and medications to any person who is 62 years of age or older. Before a certificate shall be refused, suspended or revoked, the accused person shall be furnished with a copy of the complaint and given a hearing before the board. Any person whose certificate is so suspended or revoked shall be deemed an unregistered person during the period of such suspension or revocation, and as such shall be subject to the penalties prescribed in this chapter, but such person may, at the discretion of the board, have his certificate reinstated at any time without an examination, upon application to the board. Any person to whom a certificate shall be denied by the board or whose certificate shall be suspended or revoked by the board shall have the right to review such action by appeal to the Appellate Division of the Superior Court in lieu of prerogative writ.

2. This act shall take effect immediately.

ASSEMBLY, No. 1228

STATE OF NEW JERSEY

INTRODUCED FEBRUARY 15, 1974

By Assemblyman YATES

Referred to Committee on Commerce, Industry and Professions

AN ACT requiring the Board of Pharmacy to compile a schedule of the 100 most frequently used prescription drugs, requiring every pharmacy and drug store to post a list of such prescription drugs together with their current retail price, and supplementing chapter 14 of Title 45 of the Revised Statutes.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. The Board of Pharmacy shall compile a printed schedule of the 100 most frequently used prescription drugs or medicines or combinations or mixtures thereof, and shall distribute such schedule to all registered pharmacists within the State.

2. Every pharmacy, drug store or drug department selling prescription drugs or medicines or combinations or mixtures thereof at retail, shall post a list of the 100 most frequently used prescription drugs or medicines or combinations or mixtures thereof, distributed by the Board of Pharmacy, in a prominent location in a public part of such pharmacy, drug store, or drug department. Included on said list shall be the current retail prices charged by said pharmacy or drug store for each item.

3. Any person who violates this act shall be fined not less than $100.00 nor more than $1,000.00 for each offense; to be sued for and recovered by, and in the name of the Board of Pharmacy in a civil action in any court of competent jurisdiction. Proceedings shall be pursuant to the "Penalty Enforcement Law" (N. J. S. 2A:58-1 et seq.).

4. This act shall take effect 90 days after enactment.

STATEMENT

The purpose of this bill is to require the Board of Pharmacy to compile a printed schedule of the 100 most frequently used

prescription drugs or medicines and distribute such schedule to all registered pharmacists in the State. Every pharmacy and drug store is required to post such list of the 100 most frequently used prescription drugs or medicine together with the current retail prices charged by said pharmacy or drug store in a prominent location in the pharmacy, drug store or drug department.

ASSEMBLY, No. 3263

STATE OF NEW JERSEY

INTRODUCED APRIL 10, 1975

By Assemblymen NEWMAN and DOYLE

Referred to Committee on Commerce, Industry and Professions

AN ACT concerning the practice of optometry and amending R. S. 45:12-11.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. R. S. 45:12-11 is amended to read as follows:

45:12-11. The board shall have the power, and it is hereby made its duty to refuse to grant, to revoke or to suspend for a specified time, to be determined in the discretion of the board, any license to practice optometry in the State of New Jersey for any of the following causes:

a. Loaning, selling, or fraudulently obtaining any optometry diploma, license, record, or certificate, or aiding or abetting therein.

b. Gross incompetence.

c. The obtaining of any fee by fraud or misrepresentation or the practice of deception or fraud upon any patient or patients.

d. Chronic and persistent inebriety, or the habitual use of narcotics.

e. Affliction with a contagious or infectious disease which, in the opinion of the board, renders practice of optometry by the licensee or applicant for license dangerous to the public health.

f. Conviction of a crime involving moral turpitude; or where any licensee or applicant for a license has pleaded non vult contendere or non vult to any indictment, information, allegation or complaint, alleging the commission of a crime involving moral turpitude, or where any licensee or applicant for a license presents to the board any diploma, license or certificate that shall have been obtained, signed, or issued unlawfully or under fraudulent representation. The record of conviction or the entry of such a plea in any court of this State or any other State or in any of the courts of the United

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States or any foreign country, shall be sufficient warrant for the revocation or suspension of a license.

g. Conviction in a court of competent jurisdiction of a high misdemeanor.

h. False, fraudulent or misleading advertising of the practice of optometry or of any art, skill, knowledge, method of treatment or practice pertaining thereto.

[Advertising of the practice of optometry or of any art, skill, knowledge, method of treatment or practice pertaining thereto or ophthalmic materials, fees, prices, the charges for services or ophthalmic materials, the character or durability of services or ophthalmic materials or advertising to perform optometric services or with reference to providing glasses, spectacles, contact lenses, frames, mountings, lenses or prisms free of charge or on credit or installments or anything of similar import to the foregoing, by means of circular, handbills, card, letter, sign, poster, pictures, representations of eyes or eyeglasses, advertising matches, mirrors or other articles or by advertisement in newspapers, books, magazines or other publications or by projection by means of light, electronics, crier, radio broadcasting, television or by use of an advertising solicitor or publicity agent or any other advertising media; provided, however, that any] *Any* person licensed under the provisions of this chapter may issue appointment cards or professional cards to his patients.[, when the information thereon is limited to matter pertaining to the time and place of appointment and that permitted on the professional card, or may display the name of the licensee on the premises where he is engaged in the practice of his profession upon the windows or doors thereof and by door plates, or name or office directory when the information is limited to that of the professional card. For the purposes of this section a professional card shall contain only the name, title, profession, degrees, address, telephone number, office hours of the licensed optometrist, and the words "eyes examined," "eye examinations," or "hours for the examination of eyes." The foregoing is not] *Nothing herein is* to be construed as prohibiting the publication by an optometrist of his professional card in regularly published newspapers [provided his said card and advertisement does not contain any information other than that permitted in the definition of the professional card as is found in this section].

i. Announcing his name in any city, commercial, telephone or other public directory, or directories in public or office buildings using display or boldface type or type that is in any way dissimilar

in size, shape, or color to that used for other practitioners of the healing arts in the same directory.

No optometrist shall cause or permit himself to be listed in a telephone directory under any name other than the name in which he is registered with the board as the holder of a valid, unrevoked, active license to practice optometry in this State.

No optometrist shall cause or permit any listing of any

(1) inactive, retired, removed or deceased optometrist or any other ocular practitioner, except that, for a period of not more than 2 years from the date of succession to the practice of another optometrist, an optometrist may use a telephone listing of such optometrist together with the words "succeeded by," "succeeding" or "successor to."

(2) any trade name or corporate name, or the name of any person, firm, corporation, partnership or association not licensed to practice optometry under the provisions of chapter 12 of Title 45 of the Revised Statutes of New Jersey in which additional listing the address or telephone number is the same as that of the said optometrist.

The listing of an optometrist in a telephone directory shall contain only the name, title, the word "optometrist," degrees, address or addresses, office hours and telephone number or numbers of the licensed optometrist, including, if desired, the words "if no answer, call ....."

Any optometrist listed in the classified section of any directory shall be listed only under the classification entitled "Optometrists," at the address or addresses for which he holds a valid, unrevoked, active license to practice optometry in this State.

[j. Displaying any spectacles, eyeglasses, eyeglass or spectacle frames or mountings, goggles, lenses, prisms, spectacle or eyeglass cases, ophthalmic material of any kind, optometric instruments, or optical tools or machinery, or any merchandise material, or advertising of a commercial nature in office windows or reception rooms or in display cases outside of the offices, where the display of such merchandise, material or advertising would make it visible from the street.] (*Deleted by amendment.*)

k. Displaying his licenses, diplomas, or certificates in such a manner that they may be seen from the outside of the office.

l. Using the title doctor or its abbreviation without further qualifying this title or abbreviation with the word optometrist.

m. Use by an optometrist of the words "clinic," "infirmary," "hospital," "school," "college," "university," or "institute" in

English or any other language in connection with any place where optometry may be practiced or demonstrated; provided, however, that nothing in this section shall prevent an optometric clinic, approved by the board, from being conducted on a nonprofit basis by a school or college of optometry or an association of registered optometrists.

n. The continuance of an optometrist in the employ of, or acting as an assistant to any person, firm or corporation, either directly or indirectly, after he has knowledge that such person, firm or corporation is violating the laws of New Jersey concerning the practice of optometry.

o. Any conduct which is of a character likely to deceive or defraud the public.

p. Soliciting in person or through an agent or agents for the purpose of selling ophthalmic materials or optometric services or employing what are known as "chasers," "steerers," or "solicitors," to obtain business.

[q. The issuance of appointment cards or the display of the name of the licensee on the premises where he is engaged in the practice of his profession when the information goes beyond that permitted by a professional card.] (*Deleted by amendment.*)

r. The display of the name and title of the licensee, or other information in lettering larger than 4 inches in height for street-level offices, or larger than 6 inches in height for office above street-level, and in no event shall there be more than three such displays, and the illumination of said name and title except during office hours; the use of colored or neon lights, eyeglasses or eye signs, whether painted, neon, decalcomania, or any other either in the form of eyes or structures resembling eyes, eyeglass frames, eyeglasses or spectacles, whether lighted or not.

s. Any violation of rule or regulation duly promulgated by the board hereunder or of any provision of this chapter.

t. No optometrist shall cause or permit the use of his name, profession or professional title by or in conjunction with any association, company, corporation, or nonlicensed person, in any advertising of any manner.

[u. Practicing optometry in any retail or commercial store or office not exclusively devoted to the practice of optometry or other health care professions where materials or merchandise are displayed pertaining to a business or commercial undertaking not bearing any relation to the practice of optometry or other health care professions; providing, however, that any optometrist practic-

ing in premises of this type prior to January 1, 1963, shall be permitted to continue in his present location; but when and if any optometrist, who is a lessee or an employee of a lessee, vacates such premises no other optometrist shall be permitted to practice in said vacated premises. Practicing optometry under a false or assumed name, or upon a salary, commission, or any other basis of compensation, while directly or indirectly employed by or associated or connected as an optometrist with any person, association or corporation other than one who possesses a valid unrevoked certificate of registration as an optometrist or a physician licensed in and for the State of New Jersey and who has an actual legal residence within the State.] (*Deleted by amendment.*)

v. Prior to prescribing for or providing eyeglasses or spectacles a complete minimum examination shall be made of the patient to determine the correct lenses necessary for such a patient. The requirements of such minimum examination shall be defined by rule or regulation of the New Jersey State Board of Optometrists.

w. Any person licensed as an optometrist who violates section 45:12–11 (i), (h), (m), [(q),] or (r) of this chapter shall, at the discretion of the board, be subject to a penalty of $50.00 for the first offense and $200.00 for each subsequent offense in lieu of the suspension or revocation of his license.

x. Any person who has been guilty of gross malpractice or gross neglect in the practice of optometry which has endangered the health or life of any person.

Proceedings for the revocation of a certificate or suspension of the right to practice shall be begun by filing with the board a written charge or charges against the accused. These charges may be preferred by any person or the board may on its own motion direct its secretary to prefer the charges.

2. This act shall take effect immediately.

STATEMENT

This bill will allow optometrists to advertise and to practice optometry in a retail or commercial store or office, which practices were previously proscribed by statute. Without in any way limiting the standard of health care and protection for the public, the legislation will have the effect of benefiting the consumer by permitting more informed and less expensive choices with respect to the purchase of eyeglasses and like products.

ASSEMBLY, No. 3264

STATE OF NEW JERSEY

INTRODUCED APRIL 10, 1975

By Assemblymen DOYLE and NEWMAN

Referred to Committee on Commerce, Industry and Professions

AN ACT to amend "An act providing for the regulation of the practice of ophthalmic dispensing; authorizing the issuance of certificates to registered qualified ophthalmic dispensers and ophthalmic technicians; creating an examining board to determine their respective qualifications and conferring powers and duties thereupon; and providing for penalties for violations of the provisions hereof, and supplementing the "Department of Law and Public Safety Act of 1948," approved October 15, 1948 (P. L. 1948, c. 439)," approved June 18, 1952 (P. L. 1952, c. 336).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 17 of P. L. 1952, c. 336 (C. 52:17B–41.17) is amended to read as follows:

17. It shall be lawful for an ophthalmic dispenser or ophthalmic technician to advertise**[**; provided, that no motion shall be made, either directly or indirectly by any means whatsoever, of a discount, any definite or indefinite price or credit terms on corrective ophthalmic lenses, frames, complete prescription or corrective glasses; and**]** provided**[**, that**]** such **[**ophthalmic dispenser or ophthalmic technician does not advertise in any manner that**]** *advertising* would *not* tend to mislead or deceive the public or **[**that would**]** in any manner discredit others in the eye care field. An ophthalmic dispenser or ophthalmic technician shall have the right with each individual patient to recommend an ophthalmologist or optometrist.

It shall be unlawful to advertise or employ displays in such a manner as to suggest, infer or indicate that persons licensed under

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this act are qualified to give professioanl advice concerning eye care.

It shall be unlawful for any ophthalmic dispenser or ophthalmic technician to use the word "licensed" or any of its synonyms.

It shall be unlawful for any ophthalmic dispenser or ophthalmic technician or employee or agent thereof or any other person on their behalf to offer to pay a rebate or commission in any form whatsoever to any ophthalmologist, refractionist, or optometrist in return for referring patients to anyone licensed under this act.

2. This act shall take effect immediately.

STATEMENT

This bill will allow ophthalmic dispensers and technicians to advertise, which advertising was previously proscribed by statute. It will have the effect of allowing the consumer to shop comparatively for lenses, frames, prescription or corrective glasses and thereby make more informed and less expensive choices with respect to such products.

ASSEMBLY, No. 3273

STATE OF NEW JERSEY

INTRODUCED APRIL 10, 1975

By Assemblyman YATES

Referred to Committee on Commerce, Industry and Professions

AN ACT permitting the advertising of retail prices of prescription drugs and requiring that retail prices be posted for certain commonly dispensed prescription drugs and amending R. S. 45:14–12.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. R. S. 45:14–12 is amended to read as follows:

45:14–12. The board may refuse an application for examination or may suspend or revoke the certificate of a registered pharmacist or a registered assistant pharmacist for any of the following causes: When the application or registration is shown to have been obtained by misrepresentation or fraudulent means or when the applicant or registrant is guilty of chronic or persistent inebriety, or has been adjudged guilty of violating any State or Federal law or any law of the District of Columbia or of any territory of the United States relating to the practice of pharmacy, or relating to the dispensing of drugs, or has been convicted of a crime involving moral turpitude, or has impersonated an applicant for registration before the board or has been convicted of knowingly, intentionally or fraudulently adulterating or causing to be adulterated drugs, chemicals or medicinal preparations or has sold or caused to be sold adulterated drugs, chemicals or medicinal preparations knowing, or having reason to know, that same were adulterated, or has procured or attempted to procure registration for another by misrepresentation or fraudulent means, and the board shall refuse an application for examination or suspend or revoke the certificate of a registered pharmacist or a registered assistant pharmacist when the applicant or registrant is shown to be addicted to the use of narcotic drugs, or has been convicted of violating any law of

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this or any other state or of the United States relating to narcotic drugs or has been adjudicated an incompetent, or is shown to have any abnormal physical or mental condition which threatens the safety of persons to whom said applicant or registrant might sell or dispense prescriptions, drugs, chemicals, medicinal preparations or devices or for whom he might manufacture, prepare or package, or supervise the manufacturing, preparation or packaging of prescriptions, drugs, chemicals, medicinal preparations or devices. In addition, the board may refuse an application for examination or may suspend or revoke the certificate of a registered pharmacist or a registered assistant pharmacist upon proof satisfactory to the board that such registered pharmacist or such registered assistant pharmacist is guilty of grossly unprofessional conduct and the following acts are hereby declared to constitute grossly unprofessional conduct for the purpose of this act.

a. Paying rebates or entering into an agreement for payment of rebates to any physician, dentist or other person for the recommending of the services of any person.

b. The providing or causing to be provided to a physician, dentist, veterinarian or other persons authorized to prescribe, prescription blanks or forms bearing the pharmacist's or pharmacy's name, address or other means of identification.

c. [The promotion, direct or indirect, by any means, in any form and through any media of the prices for prescription drugs and narcotics or fees or for services relating thereto or any reference to the price of said drugs or prescriptions whether specifically or as a percentile of prevailing prices or by the use of the terms "cut rate," "discount," "bargain" or terms of similar connotation, but this shall not include the term nonprofit if such term is used by a nonprofit entity; and this paragraph shall not be construed or apply to have any effect with respect to sales made by pharmacists or pharmacies directly to physicians, dentists, veterinarians or other persons authorized to prescribe, or to hospitals, nursing homes, governmental agencies, or other institutions licensed under Title 30 of the Revised Statutes, as amended or to the advertising or issuance of trading stamps and similar devices in connection with the sale of said prescription drugs and narcotics.] (*Deleted by amendment.*)

d. The claiming of professional superiority in the compounding or filling of prescriptions or in any manner implying professoinal superiority which may reduce public confidence in the ability, character or integrity of other pharmacists.

e. Fostering the interest of one group of patients at the expense of another which compromises the quality or extent of professional services or facilities made available.

f. The distribution of premiums or rebates of any kind whatever in connection with the sale of drugs and medications provided, however, that trading stamps and similar devices shall not be considered to be rebates for the purposes of this chapter and provided further that discounts, premiums and rebates may be provided in connection with the sale of drugs and medications to any person who is 62 years of age or older. Before a certificate shall be refused, suspended or revoked, the accused person shall be furnished with a copy of the complaint and given a hearing before the board. Any person whose certificate is so suspended or revoked shall be deemed an unregistered person during the period of such suspension or revocation, and as such shall be subject to the penalties prescribed in this chapter, but such person may, at the discretion of the board, have his certificate reinstated at any time without an examination, upon application to the board. Any person to whom a certificate shall be denied by the board or whose certificate shall be suspended or revoked by the board shall have the right to review such action by appeal to the Appellate Division of the Superior Court in lieu of prerogative writ.

2. This act shall take effect immediately.

STATEMENT

This bill will permit the advertising of the retail prices of prescription drugs and will require the posting in a particular pharmacy of the prices of certain commonly dispensed prescription drugs. It will have the effect of granting the consumer the opportunity to comparison shop for prescription drugs and thereby make more informed and less expensive decisions with respect to the purchase of such drugs. Such advertising and posting was previously proscribed by statute.

I N D E X

I N D E X (Continued)

I N D E X (Continued)

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ASSEMBLYMAN BYRON M. BAER (Chairman): The hearing will come to order. This is the second day of a public hearing of the Assembly Commerce, Industry and Professions Committee on Assembly bills 736, 1228, 3263, 3264, and 3273.

Our first witness today will be Mr. Robert J. Hart. Welcome, sir.

R O B E R T J. H A R T: Thank you, sir. I will read a prepared statement that was drafted by the State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians of New Jersey. I have distributed copies of the statement to committee members together with copies of the current statute regarding standards and tolerances for eyeglasses in the State of New Jersey. (Reading)

The Act providing for the regulation of the practice of ophthalmic dispensing became law in 1952 containing a provision that an ophthalmic dispenser or ophthalmic technician may not advertise price. This provision, in the Board's experience, has acted effectively to safeguard the public against the deceptive practice of bait and switch advertising.

Our concern with Assembly bill 3264 is solely with regard to the protection of the eyeglass wearing public. Assuming that the Consumer Fraud Act i s s t r o n g enough, and assuming that the continued prohibition against advertising that would tend to mislead or deceive the public is a sufficient safeguard against potential offenses such as bait and switch advertising and misrepresentation of quality of lenses and frames, there is still an area in which the consumer can be, and must be, protected by law. That is the area of accuracy of the fabrication of the lenses to the prescription and the correct fitting of the eyeglasses to the specific person for whom the eyeglasses were prescribed.

In September 1974, the Board's rule outlining

the minimum standards which all corrective eyewear dispensed in the State of New Jersey must meet became part of the Administrative Code. These minimum standards and tolerances are consistent with those adopted by the New Jersey Division of Health Assistance and Services for Medicaid and are derived from the standards developed by the American National Standards Institute, a national organization from all areas of the eye care field, which include ophthalmologists, optometrists, opticians, manufacturers, and wholesalers. It is also our understanding that the Federal Drug Administration, although it has not formally adopted the ANSI standards, recognizes them as guidelines in the eye care profession.

It is the position of the Board that it is essential to the public good that the requirement that all corrective eyewear meet the minimum standards and tolerances as adopted by the Board be incorporated into Assembly bill 3264. In this way, the consuming public can be assured that the eyewear it has purchased, at the price advertised, is made to prescription as written by the refractionist or examiner and at no time is fabricated or dispensed below the minimum standards and tolerances that insure correct eyewear. (End of statement.)

I ask that the legislators present read the proposed amendment as submitted by the New Jersey Society of Dispensing Opticians and Technicians. Mr. Carl Baumann, President of that organization, was here until 5:00 last night, and he submitted a statement and the proposed amendment. I would like to have his statement included in the record. (See page 2 X.)

The admendment would be added after line 25, page 2, section 1. It reads: "It shall be unlawful for an ophthalmic dispenser or ophthalmic technician to sell eyeglasses which do not conform to minimum standards and

tolerances as established by the Board of Ophthalmic Dispensers and Technicians."

ASSEMBLYMAN BAER: As you read that, it differed in two places from the amendment submitted by Mr. Baumann. You substituted the word "sell" for "provide," and you omitted the word "any" before "minimum standards."

MR. HART: Yes, that's correct. We wish to make those two changes.

I would like to also express my observations of the hearing that I sat through yesterday. I spent some time between 5:00 last night and 2:00 this morning trying to get some of my thoughts together. I will read the statement I prepared and will have copies made for the committee. (Reading)

I just read a prepared statement as the Secretary of the State Board of Ophthalmic Dispensers and Ophthalmic Technicians of New Jersey. From the testimony I have heard from Dr. Papier, President of the New Jersey Optometric Association, and Mr. Katz, the legislative lobbyist for the Association of Optometrists and Opticians of New Jersey, who, I believe, stated that he represents 200 licensed opticians of New Jersey and no optometrists, I have begun to wonder if the consuming public is of any interest to either group.

If the Legislature is really interested in protecting the public's health and welfare, then, to me, both bills 3263 and 3264 should be scrapped, and a completely new bill should be considered.

Dr. Papier, who represents the New Jersey Optometric Association, expounded on the professionalism of the optometrists in New Jersey, h o w important a 16 point exam is, and how the optometrists check for glaucoma, tumors, and other diseases of the eye to prevent blindness and give the consuming public the benefit of their expertise and judgment - and the end

result is still a pair of eyeglasses at a fee somewhere between $25 and $35 for a pair of single vision glasses. This is composed of $13 for a fitting or a professional fee plus the actual cost of materials plus the $20 or $21 examination fee.

Mr. Katz, speaking for the Association of Optometrists and Opticians, did not mention any particular fee for a pair of single vision, bifocal, trifocal, or any other kind of glasses, and I don't particularly care what fees any of the groups charge, whether they are optometrists, highway-type opticians, guild opticians, or just plain old-fashioned opticians. My only concern is for the accuracy of the glasses made.

I do know that, if we really want to protect the consumer, then a bill should be written that would establish a State Board of Examiners, one that states that "a refractionist shall examine eyes and provide the necessary prescription that would be best for the consumer."

It should be a bill putting some teeth into the State Board of Ophthalmic Dispensers and Ophthalmic Technicians, insuring the public's right to excellence in eye care, giving the Board the power to adopt minimum standards and tolerances as part of the statute and not as a rule, containing a continuing education and requalification program and upgrading the qualifications for licensure, providing for public as well as government members in larger numbers, establishing a hearing officer to remove the stigma from the Board of being both judge and jury, and including a provision for establishment licensing.

The present State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians has adopted standards and tolerances that have been

recommended as well within the attainable goals of what a pair of glasses should be. These standards and tolerances have been accepted by the State Board of Medical Examiners and the State Board of Optometrists as being well within attainable prescription goals. Yet, a member of the Association of Optometrists and Opticians has filed a suit in Superior Court, County of Bergen, Docket #A-546-74, to challenge these standards and tolerances and to throw them out as being unattainable goals. Hence, on the one hand, we have a group that comes before this legislative body and states that they are going to protect consumers and give them cheaper glasses through advertising; and, on the other hand, a member of that same group files a suit against the State Board to throw out standards and tolerances as being unattainable. If we honestly and truly want to give the eyeglass wearing public the best possible kind of eye examinations and the best possible pair of glasses, made correctly regardless of the cost, then, to me, a solution could and should be simple.

Establish a State Board of Refractionists or Examiners, which would consist of M.D.s, ophthalmologists, and optometrists, and a State Board of Dispensing Opticians and Technicians with policing and enforcing powers. I am making these statements because I honestly feel that, if the object of these hearings is to protect and help the health of the eyeglass wearing public, this is the only answer. Give the opticians and optometrists their price advertising provided that you also give the consuming public a law that is going to give them a pair of eyeglasses that is made correctly, regardless of the cost. No longer should the practice of an examiner also being the provider of the prescribed eyewear be tolerated. The consuming public should and must be protected. The

examiner should only examine, and the optician should only be the provider.

I wish to thank you, ladies and gentlemen of the committee, for giving me this opportunity to express my own personal views on this so-important proposed legislation. (End of statement.)

ASSEMBLYMAN BAER: Thank you very much for your testimony. I want to thank you particularly for the effort you put into preparing your statement at such late hours.

MR. HART: I have been a part of the eye care field, and my family has been part of the eye care field for four generations. I feel that such an important piece of legislation deserves my efforts.

ASSEMBLYMAN BAER: Why do you feel that it is important for the minimum standards to be adopted by statute as opposed to regulation? Are you concerned with their permanence, or are you concerned with their holding up under the legal challenge that you spoke of?

MR. HART: It is much easier for us to attack a rule that's been set than a statute. The Board had been enforcing the standards and tolerances, but, in view of the present court action, I feel that it should be protected by a statute rather than a rule.

ASSEMBLYMAN BAER: I am not unsympathetic to your desire to have standards hold up, but, particularly when you talk about highly detailed standards, it is often felt that it is more feasible to do that by regulations. Standards change; a Board can respond more readily to that. Technologies change; a Board can respond more readily to that. The Board has the expertise in terms of really understanding what the standards mean. The Legislature, even where committed to the principle of standards, often lacks the knowledge to really know whether or not those standards are as they should be.

So why, in this case, do you think it should be done by statute?

MR. HART: The minimum standards and tolerances that have been prepared were prepared through a great deal of time and effort over a period of two years by members of the State Society and Board members. All recommendations were considered, and the result is what you see before you. The important parts are those that refer to the refractive powers, cylinder axis, and location of optical center, both vertical and horizontal. These three important factors would not change regardless of advanced technology. The doctor, the optometrist, or the ophthalmologist, medical eye doctor, writes a prescription which, by law, the optician must fill accurately. He must fill it accurately with regard to the power, the cylinder axis, within the tolerances acceptable, and the location of the optical center, both horizontally and vertically. These would not change regardless of advanced technology. (See page 1 X.)

ASSEMBLYMAN BAER: I can understand that. As I look at this, I notice that some of these standards are not applicable to contact lenses.

MR. HART: By law, an optician---

ASSEMBLYMAN BAER: Do you have other standards that relate to them?

MR. HART: By law, an optician cannot fit contact lenses in New Jersey.

ASSEMBLYMAN BAER: I see.

MR. HART: These have to be fitted by an optometrist or ophthalmologist.

ASSEMBLYMAN BAER: I would like to ask you two other questions on this point. Is there any challenge as to the present enabling statute under which these standards have been issued? I am talking about a

challenge insofar as the intent of that being clear in authorizing the Board to issue such standards. In other words, is there any problem here that could be corrected or avoided by any further clarification of that authority, or is that unmistakably clear? I realize that you are not going to state at a public hearing any possible vulnerability that you feel exists in this, but is there any need to address the statutes themselves to strengthen your authority?

MR. HART: The Board always operated with the impression that a pair of glasses was made within tolerances and standards by the individual opticians who had set their own standards and tolerances. Some would be much more effective than what the Board has implemented, and others got to the point where there just weren't any standards and tolerances. So the Board, through consumer complaints brought before it, had to take the action that minimum standards and tolerances should be drawn up and that a pair of glasses should be expected to fall within the standards and tolerances of the Board.

The Board, in the past three years, has been faced with more and more consumer complaints which came down to the following: the refractive powers being too far off of the written prescription, the axis being too far off of the written prescription, and the pupillary measurements being too far off to be acceptable. This is why the Board made minimum standards and tolerances proposals.

ASSEMBLYMAN BAER: You have made a number of points that I don't want to pursue at this hearing but that are very valuable in terms of protecting the public, that is, continuing education, strengthening qualifications for licensure, public members on the Board, and the separation of powers in terms of the hearing officer. If there is

any more detailed material on your recommendations along those lines, I would appreciate your providing it.

MR. HART: I will be glad to get whatever I can for you.

The Board has been working with a government member who has been invaluable. We have also had a public member, but we have had problems keeping public members because of the "no pay" stipulation regarding people serving on the Board.

ASSEMBLYMAN BAER: I understand. When you submit this more detailed information, would you also cover the point that you raised insofar as the division of activities between the examiner and the provider? Where do you think the weaknesses are in terms of the enforcing and policing powers?

MR. HART: The Board, of course, has been operating with the enforcement bureau, and we really have not had too much difficulty in getting an inspection if we ordered one. I think it should be at the discretion of the Board to have investigators walk into any optical establishment in the State of New Jersey, go to the drawer containing the finished work waiting to be picked up by the consumers, and have the power to inspect and examine any number of glasses.

ASSEMBLYMAN BAER: Can you do it now, or do you have to make an appointment?

MR. HART: We cannot do it at this point. On notice from the Board, the inspecting division can walk in, on a consumer complaint, and ask for records that might be available. They have a little difficulty, I understand, insofar as subpeona powers are concerned. Some of these things should be worked out much better.

ASSEMBLYMAN BAER: I would also appreciate it if you could submit to us any further details as to the powers that should be granted, including your own

proposals or detailed proposals of others.

Are there any questions? Assemblywoman Curran.

ASSEMBLYWOMAN CURRAN: Why can't you do these kinds of things? Is it the overall set-up of Consumer Protection?

MR. HART: The Board's powers are different than Mrs. Annich's Division. By statute, we are fairly limited as to what type of investigation we can call for.

ASSEMBLYWOMAN CURRAN: I'm not trying to embarrass you. I just want to make sure I have my thinking right in regard to Consumer Protection. Your Board's powers are limited, but, because your Board operates under Consumer Protection, isn't it its function to refer anything to them?

MR. HART: We have to refer or request.

ASSEMBLYWOMAN CURRAN: But, if you request it, I believe that the Division is set up right now so---

MR. HART: We will get it very quickly. I feel that there should be a separate force, attached to the Board, of opticians that would be able to walk into any optical establishment in the State and look at the finished products that are awaiting the consumer. If the glasses were not up to standards and tolerances, they could not be dispensed.

ASSEMBLYWOMAN CURRAN: Practically speaking, no matter who has what powers under the law, there really isn't anyone across the street who knows what eyeglasses should look like when they're finished.

MR. HART: Yes, that is part of the problem. Most of the people in the inspecting division of Consumer Affairs would not be able to walk in, pick up a pair of glasses, and tell whether the refractive power was correct, whether the axis was correct, or whether the centers were correct. I think this is why it should be

enforced by experienced people.

ASSEMBLYWOMAN CURRAN: Thank you.

ASSEMBLYMAN BAER: Mr. Rys.

ASSEMBLYMAN RYS: You mentioned ANSI in your statement. What does that stand for?

MR. HART: American National Standards Institute.

ASSEMBLYMAN RYS: Did ANSI prepare the standards contained on the sheet you distributed to us?

MR. HART: Those are a combination of ANSI standards, Board recommendations, and proposals that were set forth at public hearings, but they are very close to national ANSI standards.

ASSEMBLYMAN RYS: Could you possibly give me the filing date of the case in Bergen County against your Board?

MR. HART: I'm sorry; there's no date on my copy of the case.

ASSEMBLYMAN BAER: Mrs. Curran.

ASSEMBLYWOMAN CURRAN: I apologize for not being able to be here earlier. On the record, but unofficially, I can understand your purpose in saying that you could not support advertising without these kinds of standards. Again, unofficially, have you talked with any of the optometrists about what their attitudes might be in regard to this bill if these amendments are included?

MR. HART: No, I haven't spoken to any optometrists. Optometrists and opticians don't have too much of a social relationship.

ASSEMBLYWOMAN CURRAN: I just wondered if they had any thoughts on it.

MR. HART: I haven't spoken to anyone at this point, especially in the optometric field.

ASSEMBLYMAN BAER: I want to explore one other area with you for a moment. I certainly don't want to

relate this to any particular individual, but are the appointees, the public appointees, to the Board generally persons who have extensive technical knowledge and practical knowledge of what is happening in the field?

MR. HART: Yes, sir. Up until two years ago, I believe, the statute stated that the members to the Board would be appointed by the Governor from a list supplied by State Societies. I think that was changed two years ago so that appointments were made by the Governor. There are five optician members on the Board, plus the government member, plus the public member.

ASSEMBLYMAN BAER: My question was about the public member only.

MR. HART: The public member has had no experience in the optical field.

ASSEMBLYMAN BAER: Is the public member sometimes less effective as a member of that Board because of his lack of technical knowledge, and is it possible to find public members who have that knowledge and yet do not come from the same professional working field so that there can be no question as to their representing the same viewpoint? Is there a feasibility, for instance, for making stronger appointments from persons who come from the academic field and have a great deal of knowledge in these areas or from other fields where this knowledge would exist; that is, where there would be a high degree of knowledge but not the same experience in previous occupational connections that might lead to the same perspective or cause the public to question whether or not there is a different viewpoint?

MR. HART: With my limited experience with the public member of our Board, it really shouldn't make any difference if you get a dedicated, qualified person

who wants to serve on the Board. I feel that they have been a big help and advantage. The government member whom we have on our Board is a member of the Department of Health. He has had no experience whatsoever in the eye care field, and, yet, his help and guidance to the Board have been immeasurable. If a person wants to serve on the Board, I don't think his educational background is as important as his common sense.

ASSEMBLYMAN BAER: Thank you very much. We appreciate your taking the time to prepare your statements and to come here to testify.

MR. HART: Thank you, sir.

ASSEMBLYMAN BAER: The next witness will be Dr. Richard Appel of the New Jersey Society of Optometry.

R I C H A R D S. A P P E L: I am Dr. Richard Appel. I practice optometry in Eatontown, New Jersey. I graduated from optometry school in Philadelphia in 1970, and I worked in New York for a little over a year. Then I opened my practice in Eatontown about two and a half years ago. With me is my group's attorney, Bruce Fadem. I am the Chairman of the Board of Directors of my Society, and I am here to represent them.

In regard to A-3263, we are in favor of Section U which your committee introduced a few weeks ago. We are very strongly in favor of it because of the abuses that will be allowed to occur if optometrists are allowed to be employed by opticians. The amendment basically continues making it illegal for opticians or other lay people to employ optometrists. Optometrists are professionals; we have a high code of ethics; we are primarily interested in the public welfare and the public interest. Opticians are lay people. Their

interest is primarily monetary. They are out to make as much money as they possibly can. If it is made legal for optometrists to be employed by opticians, the optometrists will be used by the opticians for the opticians' goal of making more money. The expense will be at the public interest.

I worked in New York for about a year, as I said, and, in New York, it is legal for optometrists to be employed by opticians, by lay people. In New York I was in contact with many optometrists who were employed by opticians. I became aware of the abuses that occur there simply because the optometrist has to answer to his boss. In New York the time that a doctor can spend with a patient is limited by the optician's desires. The optician, of course, would like to make as much money as possible. Consequently, the optometrist is a very high-cost employee, and he has to utilize the optometrist to his best interest.

If the optician desires to keep the optometrist as busy as possible, it prevents the optometrist from spending as much time as he would like with certain patients. Some patients are routine; they don't require a great deal of time for a complete examination. Others, however, do require extra time, for example, elderly patients and those with individual problems. You have to spend this time with them. In New York it is very difficult to do that if the optometrist is employed, because his object is to produce as much as he can for his employer. Otherwise, he may lose his job.

The fee schedule is also dictated to the optometrist. The optometrist is working in an establishment. He goes in in the morning, he knows how many people he is going to see, as many as possible, and the fee is dictated to him. The fee

is usually kept very low to stimulate business; it's used as a leader. The low fee will bring people in. They think, "Oh, it's terrific." They go through the examination, and the object is to sell the eyeglasses. This is what happens.

Another problem is that, in certain instances, the prescription can be dictated to the optometrist. The optometrist comes up with a certain prescription. In talking about what happens in New York, many opticians advertise very fast service, one hour service, same day service, etc. If they happen to be out of stock of a certain lens that the patient needs, rather than lose the sale, the optometrist may be forced to change his prescription. Let me give you a little background: You examine a patient. The patient needs a certain prescription to give him the best visual efficiency he can have, to see the best, and to be the most comfortable he can. The majority of patients do not have to wear that prescription. You can give prescriptions a little bit stronger or a little bit weaker, and they will be able to wear them. The problem is that they will not be able to perform as efficiently as they could if they were given the exact prescriptions. If the optician is advertising fast service and they are out of stock of the lenses when the patient comes in, rather than lose the sale, the optician may go to the optometrist and say, "We have to change the prescription, or we'll lose the sale." Or, the optician may change the prescription on his own and give the patient something that is convenient for him but detrimental to the patient.

Another problem that occurs in New York, and would occur in New Jersey if this were allowed to happen, is the desire of the optometrist to actually sell eyeglasses, to push them upon the patients. Are you

familiar with what a "spiff" is? Let's say that the optician is overstocked with a certain frame, and he wants to push the f r a m e because he got a terrific buy, and he wants to sell a lot of frames. He'll say to the optometrist, "If you sell this frame to a patient, we'll give you a dollar. If you sell another one, we won't give you anything." The optometrist, being an employee, is going to go out and--- It's sad but, if his livelihood depends on his selling one frame rather than another, he will be induced to do it.

If the optometrist is employed by the optician and it's a large corporation, there may be profit-sharing involved also. The optometrist may be given a piece of the action. That means that, if a patient comes in who needs no change in prescription or no glasses, he may sell a pair of glasses to the patient telling him, "Yes, there is a change," or "Yes, you need glasses; go outside and pick out a nice frame," even though the patient may not need a change or may not need glasses, simply because of the motive of profit-sharing or because, as I said before, he'll profit from selling a certain frame.

Another problem that would evolve, and that I feel is extremely serious, involves certain patients such as diabetics. If, during the examination, I come across a diabetic patient who is not aware of the condition, I tell the patient to see a medical doctor.

Let me digress for a moment. My group, New Jersey Society of Optometry, consists of non-dispensing optometrists. We do not sell glasses. We simply examine the eyes, and many of us fit contact lenses. We have no interest at all in the sale of glasses. We make no profit from it in any way, shape, or form. Our only source of income is derived from examinations and from fitting contact lenses if we do that.

Now, in view of that, if a patient comes into my office and, during the examination, I see that he is diabetic, I will not prescribe glasses until the diabetes is brought under control. In a diabetic, as the blood sugar fluctuates, the vision and prescription needed will also fluctuate. Therefore, if I prescribe a pair of glasses now, and he sees an M. D. and has the diabetes brought under control, he will need a different prescription in the future. Therefore, I tell him, "Go see your physician, have the diabetes brought under control, and then I will prescribe glasses."

If an optometrist is employed by an optician, his interest is selling glasses. His interest is not the patient's welfare. The optometrist will be hindered from actually giving the patient the best care he can. In a case like this, he will be selling the patient a pair of glasses, the patient will then go to a physician and have his blood sugar brought under control, and then he will have to come back in and buy a second pair of glasses or a third pair depending upon how severe the diabetes is and how difficult it is to bring it under control.

As an employee, the optometrist will want to keep his job. It will be in his best interest to do what he can to make his employer wealthy, because if he makes money for his employer, obviously his employer will keep him. If he doesn't do the optician's bidding, he can lose his job.

As an independent optometrist in my own practice, my reputation is at stake. When a patient comes to me, I want to do the best I possibly can for him. An employed optometrist who works for an optician will just be putting his time in. His reputation isn't at stake. He will do what he has to do according to the law, but

the quality of care will be lost in this situation. He is not going to be doing the best he can for the patient. He is going to be doing the best he can to keep his job and to satisfy his employer. Who is going to lose out? The patient.

I would like to make an analogy: If it were legal for a physician to be employed by a lay person, the situation would be the same. The lay person would be interested in the utilizing the M.D.'s time as best he could to produce as much money for himself as possible. He would dictate to the physician how much time he could spend with patients. Certain patients need much more time than others insofar as the examination is concerned. He would also dictate the fee structure. The doctor's hands would be tied. He would be, again, an employee, and he would be limited in what he could do. He would do what he could, of course. However, if his time were limited, his hands would be tied. If he saw something that he wanted to pursue but his time was up with that patient, what could he do?

The same thing would apply to an attorney. If an attorney were employed by a paralegal and his time had to be utilized in a certain fashion to make as much money as possible for his employer, the same situation would occur.

The optometrist would not perform to his maximum. He would be more concerned with keeping his job, and, if he was making money on "spiffs" or profit-sharing, this would shade his performance also.

I would like to bring up one other point: I think what we are doing here is good. However, I feel that we are taking a piecemeal approach to the situation. The optometric code, which I hold here, was mostly promulgated in the early 1950s. A lot has occurred

since then, and a lot of the rules are outdated. In 1950, paralegal, paramedic, and paraoptometric were terms that were unheard of. Today an optometrist in New Jersey has to do a complete minimum examination of 16 points, a fact which I am sure you are aware of. Some of these points don't have to be done by the optometrist. There are certain machines which nurses use in schools and which a qualified lay person can be taught to use. This could save time for the optometrist. The patient would still be getting the good, quality care that he is entitled to and deserves; however, it would reduce the time that the optometrist would have to spend with the patient. Consequently, he could reduce his fees. He would be spending less time and therefore would not have to charge as much. The care would be as good, if not better, because these machines can be used by lay persons if instructed properly. They can do certain tests as well as, if not better than, the optometrist by using these machines. Again, the patient will benefit from this. If fees can be reduced because of the use of machines, I think it should be done. This book does not mention optometric assistants. This book is outdated. Many of the laws are good and should be continued. However, there are some which are hindering the patients, the public, from getting the kind of care they can get at a price which is as low as possible. They are also hindering optometrists from performing as well as they can in the public interest.

As a representative of my group, I feel that it would be wise for the committee to consider having a subcommittee to review the book, the entire code, and see if there are possibly other things that should be changed to help the public. If this is the case, I am here to offer to you any help I can. We will do whatever we can to help make this book more up-to-date so the public can be better served.

ASSEMBLYMAN BAER: Thank you, Dr. Appel. Are there any questions? Mrs. Curran.

ASSEMBLYWOMAN CURRAN: One of the problems that the legal profession has with using paralegals is that there is a great deal of concern that, although many lawyers are using paralegals, they are charging for them. Is there any indication that because paraoptometrics are used---

MR. FADEM: They are not used.

ASSEMBLYWOMAN CURRAN: They are not used?

MR. FADEM: Presently, under the law, the 16 points can only be performed by a licensed optometrist. A simple test for color blindness---

ASSEMBLYWOMAN CURRAN: A licensed optometrist or a nurse in school.

MR. FADEM: No. Absolutely not.

ASSEMBLYWOMAN CURRAN: Dr. Appel, I thought you said that these machines were used by nurses in schools.

DR. APPEL: They are used as screening devises only. They check the children out. If a child seems to be having a problem, they will refer him to an optometrist or ophthalmologist.

ASSEMBLYWOMAN CURRAN: They are used only as screening devises then?

DR. APPEL: Yes.

ASSEMBLYWOMAN CURRAN: The position of your group, then, is that, obviously, if someone else is able to use these machines, costs definitely would be reduced, is that correct?

DR. APPEL: They definitely would be.

ASSEMBLYWOMAN CURRAN: Is there any basis for saying that they definitely would be reduced? Can you cite another State where this program is in effect and has resulted in reduced costs?

DR. APPEL: I really don't know if there are any

States with such a program.

ASSEMBLYWOMAN CURRAN: You mentioned the possibility of an optometrist writing a prescription for certain lenses that were not in stock, so the prescription would be changed. Is it illegal in New York for the optician to change the prescription?

DR. APPEL: I don't think it is, but that abuse does occur.

ASSEMBLYWOMAN CURRAN: I just wondered if it is illegal.

DR. APPEL: To my knowledge, no.

MR. FADEM: It is my understanding that only an optometrist can render a prescription for optometric purposes in New York.

ASSEMBLYWOMAN CURRAN: Then we can assume it is illegal even though the practice does go on, and it is the enforcement that is the problem.

MR. FADEM: Yes.

ASSEMBLYWOMAN CURRAN: I am thinking of the whole question of reviewing the Board and the enforcement procedures.

MR. FADEM: There is an economic advantage in being able to go to your employee and say, "It would be easier to sell a pair of glasses with a minute change in this prescription."

ASSEMBLYWOMAN CURRAN: That's a different point, though. The doctor mentioned two things: They go back to the optometrist and ask him to change it, and sometimes they change it on their own. I wanted to clarify whether that was legal.

Your testimony was very interesting, doctor. You'll have to forgive us; we are not experts in your field. We hear from one group that the non-dispensing optometrists are the bad guys, and, from another, we hear that the dispensing optometrists are the bad guys. We are trying to sort everybody out. Tell me briefly

why you are a non-dispensing optometrist when you do dispense contacts.

DR. APPEL: I don't understand the question.

ASSEMBLYWOMAN CURRAN: Why are you called a non-dispensing optometrist when you do prescribe and, I assume, dispense contact lenses? I don't actually see the difference between contacts and glasses from a professional viewpoint.

DR. APPEL: Monetarily, there is a large difference, because the vast majority of my patients and, to my knowledge, the vast majority of all the optometric patients in the country get glasses. Let's say that the gross income of the average optometrist is $10,000 a year. He may make $1000 a year by dispensing contact lenses. This is a very small part of the optometric practice - extremely small.

ASSEMBLYWOMAN CURRAN: Alright, now, let's take an optometrist, dispensing or non-dispensing, who makes $10,000 a year from examination fees, to begin with.

DR. APPEL: O.K.

ASSEMBLYWOMAN CURRAN: Then we have some optometrists who also make, let's say, another $10,000 a year for providing the glasses. Is that fair?

DR. APPEL: O.K.

ASSEMBLYWOMAN CURRAN: Then there's another group, your group---

DR. APPEL: No. You have to add contacts.

ASSEMBLYWOMAN CURRAN: Alright. Add another $1000 for contacts. Then there's your group which makes, say, $10,000 for examinations and another $1000 for dispensing contacts, is that right?

DR. APPEL: On the average, assuming that everything is equalized.

ASSEMBLYWOMAN CURRAN: Then that's basically

all we're talking about insofar as optometrists are concerned. Are these the only categories?

DR. APPEL: In New Jersey.

MR. FADEM: There are also ophthalmologists, M.D.s that prescribe glasses.

ASSEMBLYWOMAN CURRAN: That's a very small group, isn't it?

MR. FADEM: Yes.

ASSEMBLYWOMAN CURRAN: When you examine someone and you realize that they need something to correct their vision, what would be the difference between prescribing glasses and prescribing contacts? I always thought that anybody who had glasses could also get contacts.

DR. APPEL: False.

ASSEMBLYWOMAN CURRAN: That's what I want to clarify. I am sure that some people cannot wear contacts, but what is the difference?

DR. APPEL: There is a large percentage that cannot.

ASSEMBLYWOMAN CURRAN: The difference, basically, then is just the number of prescriptions for contact lenses?

DR. APPEL: Some patients come to me or call and ask to be fitted for contact lenses. I will set up a separate appointment to fit them for contacts. The vast majority of my patients are simple, routine examinations where I write a prescription for glasses, and that is it. I hand it to them, and they take the prescription wherever they want and have it filled, and they bring the glasses back so I can check them out and make sure that they were made properly. Contact lenses consist of a very, very small percentage of my practice. Very few people wear contact lenses compared to glasses.

ASSEMBLYWOMAN CURRAN: But you do order these little lenses--

DR. APPEL: Right.

ASSEMBLYWOMAN CURRAN: --and sell them to your patients.

DR. APPEL: I sell my services insofar as my fitting them, my following up on the examination, my teaching them how to take care of the lenses, etc.

ASSEMBLYWOMAN CURRAN: I don't mean to belabor the point, but I think that a lot of us are more in the dark than you professionals realize. Is it more expensive for an average person, not someone with a severe eye disease, to have glasses or contacts?

DR. APPEL: Contacts are more expensive.

ASSEMBLYWOMAN CURRAN: Contacts are definitely more expensive?

DR. APPEL: Oh, sure. They also have to be replaced. Contacts do not last forever. Soft lenses last maybe nine months to a year if you're lucky, and they are very expensive.

ASSEMBLYMAN BAER: Mr. Rys.

ASSEMBLYMAN RYS: Dr. Appel, why would a degreed person, an optometrist, work for an optician?

DR. APPEL: Possibly because he cannot make it on his own. It is expensive to open a practice. The cost of the equipment is prohibitive.

ASSEMBLYMAN RYS: Wouldn't it be better for him to work for another optometrist?

DR. APPEL: Yes, if he can get a job working for another optometrist. It's easier to say than to do because, in New Jersey, there are very few optometrists who need associates.

ASSEMBLYMAN RYS: Don't you think it's degrading for a degreed man to work for an optician?

DR. APPEL: I'll buy that.

ASSEMBLYMAN RYS: I know you had the experience of working in New York. Can you compare working in New York with New Jersey?

DR. APPEL: In New York, broadly speaking, anything goes. We have a 16 point examination in New Jersey. In New York they joke about "four and seven out the door." One test is an objective test by the optometrist to determine what the prescription is. The second test is simply to come up with a prescription, and they're out the door. Zip, zip, and they're gone. The examination may take two minutes. Many abuses occur in New York. That is the main reason I came to New Jersey.

ASSEMBLYMAN RYS: Have you or any of your patients ever referred the charges you made today to the Board of Examiners?

DR. APPEL: Insofar as the things that occurred in New York?

ASSEMBLYMAN RYS: No, I'm talking about New Jersey.

DR. APPEL: I don't understand the question.

ASSEMBLYMAN RYS: Have your charges been brought to the attention of the Board of Examiners?

DR. APPEL: Those occurred in New York.

ASSEMBLYMAN RYS: Have you reported anything about complaints to the Board of Examiners?

DR. APPEL: In New Jersey, no.

I would like to get back to one point. Assemblywoman Curran, you brought up the point about dispensing and non-dispensing optometrists. The optometrist who is selling glasses in this State has an interest in selling glasses. This is what I was driving at. I, because I don't sell glasses, have no such interest. If a patient comes in, and I examine him, and I come up with no prescription, I'm thrilled. If there is no change, I couldn't care less. My income is not dependent upon

my selling a pair of glasses, and this is the way I want it to continue.

ASSEMBLYWOMAN CURRAN: Are you aware, doctor, of any agreements, informal or otherwise, between non-dispensing optometrists and any opticians?

DR. APPEL: In New Jersey?

ASSEMBLYWOMAN CURRAN: Yes.

DR. APPEL: No, I'm not aware of any. Are you talking about kickbacks and things like that?

ASSEMBLYWOMAN CURRAN: Yes.

DR. APPEL: I'm not aware of any.

ASSEMBLYWOMAN CURRAN: Have you ever heard of any reports of things of this nature?

DR. APPEL: No, I haven't.

ASSEMBLYWOMAN CURRAN: I am definitely not talking about you personally.

MR. FADEM: I might reiterate what Dr. Appel said earlier. His only interest is in giving an accurate prescription after an examination. He doesn't care if the patient needs glasses or not. A non-dispensing optometrist is in that posture. A dispensing optometrist, as was brought out yesterday by a witness, makes $20 for the exam, and he also makes another $20 if he prescribes a pair of glasses which are fitted in his office. Dr. Appel is not in that latter category. His only interest is in making an accurate prescription. That might be a finer distinction between the two groups in New Jersey as they exist. That distinction would be greatly worn down if Section U were deleted and opticians were allowed to employ. Then the opticians would have a great economic interest in the practice of optometry in the State of New Jersey.

ASSEMBLYMAN BAER: Do I understand from your testimony that, when you provide a patient with contact lenses, you provide those to the patient at cost?

DR. APPEL: No. Number one, I have to order lenses, and I have to check them out to make sure they are made to my specifications. If they are not made to my specifications, they have to be done over.

ASSEMBLYMAN BAER: I am not talking about the time you spend in serving the patient. I am talking about the cost of your service. I got the impression from your testimony that you don't make anything on the lenses themselves, that you pass them along at cost, and that what you charge is for your time and service. Is that correct?

DR. APPEL: There is a markup on my contact lenses.

ASSEMBLYMAN BAER: There is a markup?

DR. APPEL: Right. However, the vast majority of my patients have insurance. Once I have examined them and fit them with contacts, if they lose a lens or need to have them replaced, it is normally done through the insurance. I make my examination fee to refit them to make sure the lenses are proper, but that is it. As I said, the vast majority of my patients are covered by insurance.

MR. FADEM: That's for a second set of lenses.

ASSEMBLYMAN BAER: I understand.

Do you concur with the proposition mentioned by the previous witness in terms of the desirability of the complete separation between prescribing and providing? You may make a distinction between contact lenses and regular lenses if you wish, but do you agree with this concept?

DR. APPEL: When you bring a commodity, something to be sold, into a situation, there is an interest in selling that item, and I would like to see it separated. That is why I don't sell glasses - simply to keep the economic interest away from the interest in giving the patient the best care.

ASSEMBLYMAN BAER: Do you feel that that separation should be made at all levels in this field?

DR. APPEL: Yes.

ASSEMBLYMAN BAER: Do you feel that it would be ultimately desirable to have that separation apply to contact lenses also?

DR. APPEL: If this were the accepted standard, yes, by all means.

ASSEMBLYMAN BAER: In reference to the comments that you made about the inadequacies of the code - you cited an example of perhaps using paraoptometrics - is the problem the inadequacy of the statutory latitude that the Board has? Do they not have the authority to make the changes that you wish, or is the problem that the Board, for whatever reason, has failed to address these problems and has perhaps a different view of the matter than you do?

DR. APPEL: I feel that these laws that were mostly promulgated many years ago don't fit the situation today.

ASSEMBLYMAN BAER: Was that code that you were describing promulgated by regulations?

MR. FADEM: It is statutory, sir. Once an area is designated as a profession, I believe it comes under the sole control of the Legislature to determine who can practice within that group.

ASSEMBLYMAN BAER: What you are referring to, then, is statutorily limited, and it is not within the authority of the Board to adjust it, is that correct? I had the impression that the 16 point examination was something that was adopted by regulations. That isn't the case?

MR. FADEM: That happens to be an administrative rule.

ASSEMBLYMAN BAER: If it was adopted by regulation, isn't who carries it out also a matter that is---

MR. FADEM: There is a limitation on who is allowed to practice optometry in the State of New Jersey.

ASSEMBLYMAN BAER: I see. That examination, then, has to be done by law, is that correct?

MR. FADEM: That's correct.

ASSEMBLYMAN BAER: Is that viewpoint also the viewpoint of the Board?

MR. FADEM: I don't know, sir.

DR. APPEL: It's not specified in the rule book.

ASSEMBLYMAN BAER: Perhaps I should ask the Board--

MR. FADEM: We cannot speak for the Board at this point.

ASSEMBLYMAN BAER: --whether there is an objection to that or whether, in fact, it is a statutory limitation.

DR. APPEL: I would like things like this to be spelled out. I would like specific rules, laws, governing these things so that, whenever something comes up, I don't have to go to the Board for its ruling.

ASSEMBLYMAN BAER: Reference was made, I believe by Assemblywoman Curran, to what the situation is in other States and whether or not a program such as you propose is in effect in other States. You indicated that you don't know. Mr. Fadem, could you provide that information to us?

MR. FADEM: I would be happy to do that.

ASSEMBLYWOMAN CURRAN: Maybe you could get a paralegal to look it up. (Laughter)

ASSEMBLYMAN BAER: Do you feel that some of the problems that you described concerning optometrists being employed by lay persons have parallels where optometrists are employed in institutional situations?

DR. APPEL: In that situation, they do not profit from selling glasses. I have no experience with institutional situations. I cannot say that I can draw a parallel, because, in an institution, the optometrist is not going to benefit from selling something. I would assume that the optometrist is much more concerned with the patients' welfare. He gets a salary whether he produces more or not.

ASSEMBLYMAN BAER: Thank you. Are there any other questions? Mr. Rys.

ASSEMBLYMAN RYS: Dr. Appel, are you a member of the New Jersey Society of Optometry?

DR. APPEL: I am the Chairman of the Board of Directors.

ASSEMBLYMAN RYS: How many people do you represent?

DR. APPEL: Approximately 25.

MR. FADEM: The Society is limited to licensed professionals in the State of New Jersey.

ASSEMBLYMAN RYS: What is the business address of this organization?

MR. FADEM: The principle place of business is registered with the Secretary of State. It is Dr. Appel's office, Wall Street and Route 35, Eatontown, New Jersey.

DR. APPEL: There is a list of members attached to the statement I distributed. (See page 4 X.)

ASSEMBLYMAN BAER: Thank you, gentlemen. We appreciate your being here to testify today.

The next witness will be Pasquale Gervasi.

P A S Q U A L E G E R V A S I: Before I speak, Mr. Chairman, I wish to call to your attention that the material that I have here has been forwarded to all the members of this Committee so that they could prepare themselves for any questions they may wish to ask me. Unfortunately, you never got this because it was mailed to the State House. But I did forward a copy of all the material to Mr. Capalbo in reference to this. You will find this material when you hit the mail box at the State House. What you have before you is the article, "The Community Pharmacist - Health Sentinel on the Home Front," which is a composite of all the material that you see here before you.

My name is Pasquale Gervasi and I am a Registered Pharmacist of New Jersey. My home address is 115 South Kingham Road, South Orange, New Jersey. Following my doctor's advice, I am no longer engaged in practicing my profession as I had been for over forty years.

I wish to thank you for this opportunity to present my views concerning Bills A 736, A 1228, and A 3273.

With your permission, I would like to digress from my script to say that although I disagree very much with Mr. Givens' testimony yesterday, there was one sentence with which I am in thorough agreement; that was when he said, the people need all the help that they can get. Please,believe me, that is the reason I am here because I do believe that people need all the help they can get.

Now I will go to my script. When almost 350 years ago, Thomas Adams wrote in his works that "Prevention is so much better than healing," he was then proclaiming what is presently the aim of every participant in the health field today.

The bills we are considering today, if enacted, will in fact not only block the attainment of that goal, but also indeed make possible the cure that is worse than the disease. With the following, we hope to establish that

the advertising and required posting of prescription drug prices are not cure-alls for the ailments that we are trying to eliminate, but actually would be a component part of those ills.

A drug - is a drug - is a drug. Used properly and with care it helps us to live, helps to preserve our health. Abused and misused, it can, and it does, destroy us physically, mentally, morally. Drugs are not Roman candles intended to delight us, but sticks of dynamite with a delayed fuse instead; for, when least expected, they explode.

At no time in the history of our country has this error in judgment in the evaluation of drugs been so starkly revealed as that which was committed by the majority of the members of the 1928 United States Supreme Court in ruling for Liggett in Liggett v. Baldridge. They failed to take heed of the prophetic views of Justices Holmes and Brandeis who had dissented with the Court's majority ruling when they declared, and I quote, in part: "The selling of drugs and poisons calls for knowledge in a high degree."

By ignoring this especial caution, a caution that must be exercised with all drugs, not only prescription drugs, we are witnessing now that this horrendous decision has, excepting for the narcotics peddler, contributed more to the catastrophic drug problems plaguing us today than any other single factor. Because this Court had catergorized prescription drugs in the retail field as common run-of-the-mill merchandise, they rammed open a "sesame" for the huckstering of medicinals that out-hawks those that are spieled for foodstuffs, wearing apparel, heavy merchandise and household wares, nourishing an undue liberty with drugs which today is so patently displayed by the enormous number of young addicts we are trying so desperately to rehabilitate, and a drug-oriented

society which indulges excessively in the unwarranted use of drugs.

Through this onerous decision, the 1928 United States Supreme Court must be regarded as one of the major participants that helped conceive these crises which presently threaten not only vital pharmaceutical services, but also through the abuse and misuse of drugs still spawns another, crime.

The 1928 majority decree was termed, "A derelict in the sea of law," on December 5, 1973, by Mr. Justice Douglas, when it was unanimously overruled by the present United State Supreme Court.

However, this corrective ruling notwithstanding, we are here today struggling to prevent the enactment of bills that would compound again that tragic mistake by the highest court in our land. This circumstance, in itself, testified to the malignant, brainwashing influence that that error has cast upon many who have lived most, if not all of their lives, under its shadow.

We pass laws to halt a suicidal plunge due to a reckless use of drugs and then encounter mandates that qualify them. An outstanding example of a paradoxical situation that has developed is the advertising proposals for prescription drugs by various federal agencies while other federal and authoritative sources condemn the same practice for drugs that are not as potent, that is, the over-the-counter drugs.

This failure, by responsible leaders in or out of government, to recognize drugs as potent products to the extent that they should be is a major element that hinders our efforts for a more effective and comprehensive delivery of pharmaceutical services.

Nevertheless, in spite of the deprecation to which community pharmacists are perennially subjected by powerful

monied interest, there is none so geared to equal the health protecting, personalized pharmaceutical services that the community pharmacist is in a position to give.

Any bit of gimmickry that will gut the community pharmacy is employed. But now a potent medium, not a gimmick, that more than ever is currently being used against it, is the Legislatures. Through them will be attempted the enactment of laws which they hope will help decimate this institution, or, failing in that, to stall or defeat any proposal that would aid it.

Influenced in no small part by the 1928 United State Supreme Court ruling, we find now arrayed with the giant conglomerates, sincere, will-meaning individuals and organizations who have been successfully swayed to generally question the motivations, principles and veracity of the community pharmacist. This altruistically-motivated support, because of the trust it commands, is more dangerous to the public's well-being than if it had been selfishly inspired. It is like putting gasoline into a fire extinguisher unintentionally.

It is our responsibility to insure that the decisions we make today do not prove detrimental to our children of tomorrow. A careless and mindless behavior is a luxury none can afford, for we are at a crucial stage in our medical history when health care affecting generations after us will soon be enacted.

We must recognize that the immediate accessibility of services which is unique to the community pharmacy is made possible simply because it is there close by and that the added benefits and portection it provides belong primarily, as does any other health service, to the people, not to their respective practioners, the drug and chemical companies, insurance companies, drug chains, supermarkets and conglomerates.

In 1963, Dr. Frances O. Kelsey, heroine of the

thalidomide case, reported that, "There is no such thing as a safe drug."

Vital statistical material compiled years before and after her warning verify it convincingly, conclusively. But firm, demonstrative acceptance of her expertise never materialized. What we have instead is a vociferous clamoring that incites demands for the passage of laws that advocate the unwise publicity and advertising of prescription drugs. We are being submerged by a line of reasoning so impregnated with a distorted sense of values that it heedlessly rejects all the deadly evidence made known to us for financial rewards that are illusionary at best. It is a mass hysteria if allowed to proceed unchecked and will surely pave to oblivion those very roads that our youth now tragically pursue. And it will enact too the axiom, "Familiarity breeds contempt"; only with drugs, not contempt is bred, but death and despair."

To dispel any thoughts you may entertain that perhaps my statementswere unduly harsh or unwarranted, I submit for your study a paper which I believe authoritatively substantiates them. It is titled, "The Community Pharmacist - Health Sentinel on the Home Front," from which a condensed version was published in the American Journal of Public Health, August, 1974.

If I may digress once again, Mr. Chairman, I wish to quote from today's Ledger in reference to Mr. Givens' statement regarding those of us who object to the advertising and to the posting of prescription drugs: "Against those who claim there are horrible consequences arising from simply telling the truth.'. . ." I am telling the truth. I have evidence before me to prove to you that there were hearings held on the advertising of over-the-counter drugs before the committee of Gaylord Nelson and also on crime in our schools before a Select Committee on Crime before Congressman Claude Pepper.

Also, quoting in part from that article in the Star Ledger, with reference to Acting Director of the State Division of Consumer Affairs, Virginia Long Annich, "She did raise eyebrows with the results of a survey done by her office that revealed wide disparities in the cost of drugs."

This led me to read this other answer to that question if it had been posed to me - I say, if it had been posed to me. I am now reading it: In response to a question that may have been asked in reference to the wide variation in prescription pricing, there are a number of valid explanations for this deplorable circumstance. However, I shall comment upon the two which I believe are 90 percent accountable for it.

First, corporate greed on the part of many of our drug manufacturers, supermarkets, chain drug and conglomerate operations, and due also to a small number of individuals who are struggling for their very existence because of the jungle warfare in the marketplace.

Second, and definitely not the least of the two, is the faulty decision with which we were blessed back in 1928 by the United States Supreme Court. It was circus impresario Barnum who in all his wisdom coined, "There is a sucker born every minute." I don't know the name of the side-show philosopher who sagely added, "with two scheming cookies right beside him, ready, willing and able to take him over." But I do know that loss leaders are operational gimmicks and come-ons that aptly fit these worldly observations to a tear-jerking tee.

There is absolutely no room for ploys such as these in the dispensing of prescription drugs. This is a peddling of potent medicinals as though they are bits and pieces of common innocuous substances. With the implementation of that onerous decree, there occurred a metamorphic change in the retailing segment of pharmacy

that inexorably forced practically every community pharmacist to ape the bargain-day sales operations if they were to survive. Big ticket promotions so submerged life and health-preserving pharmaceutical services in the public consciousness that these protective measures were literally and factually put on the open-market chopping block. Public awareness of them has been so decimated that the climate now appears to be sufficiently ripened to make numbered automatons of us all, serviced by robotistic pharmacists.

Other evidence of the disastrous aftermath that has been caused by the 1928 ruling is vividly confirmed by the testimony given on the advertising of proprietary medicines in 1971 before a United States Subcommittee chaired by Senator Gaylord Nelson and a 1973 report on Drugs in Our Schools from testimony presented to the United States Health Select Committee on Crime chaired by Congressman Claude Pepper.

Now add to these reports, please, the many, many millions of dollars that have been fruitlessly allocated in our sad attempts to restore to sound mind and to sound body those who have been struck down because of the promiscuous use of drugs. Double the sum. You have now the approximate total if those who advocate the enactment of these bills succeed. Why, we ask, is there such a wide variance in the pricing of a prescription? There would be no need for that query if we would but view the loss-leading of drugs as the despicable tactic it has been proven to be. It would be totally unrealistic for me to assert that there are conniving charlatons in other professions and trades and not acknowledge that they are also with us in pharmacy.

Our job then is to exterminate those causes that enable this breed to flourish and grow and not to furnish the fertilizer that it wantonly seeks.

In closing, I would say, you will be obliged to evaluate the pros and cons that all of those concerned about these bills have been permitted to spout. To plunge deeply into this torrential flood and determine whether what has been poured is expressed also by a compassionate tear - or a crocodile's.

Thank you.

ASSEMBLYMAN BAER: Thank you very much.

Any questions?

ASSEMBLYMAN RYS: I don't have any questions, but I just wanted to congratulate Mr. Gervasi upon his testimony and the patience he exhibited. I know he spent all day listening to everyone else. I welcome his testimony and appreciate it very much.

MR. GERVASI: Thank you very much, Assemblyman Rys.

ASSEMBLYMAN BAER: I share those sentiments and appreciate your public mindedness in coming here and preparing all this information. And I appreciate the fact that you are not a new-comer to the field.

MR. GESER: Mr. Baer, may I ask that the fact be added to the record that Mr. Gervasi also testified before the Legislative Committee in 1963 on subjects also relating to the overuse of drugs.

ASSEMBLYMAN BAER: Very good. Was any of that related to advertising legislation?

MR. GESER: Well, at that time, we were attempting to persuade the Legislature to control the sale of over-the-counter drugs which we had identified even long before as a problem, and Mr. Gervasi was one of the key witnesses with substantial evidentiary proof.

MR. GERVASI: Mr. Chairman, may I also add, all the pertinent information that you see has been forwarded to you and I shall be happy to add to it. I really hope that you will go through it with a fine-toothed comb and I will be happy to answer any questions that you may

call upon me to answer at any future time. (See page 9 X.)

ASSEMBLYMAN BAER: Thank you very much.

The next witness is Mr. Robert Wunderle.

R O B E R T W U N D E R L E: Chairman Baer and Assemblyman Rys, I thank you for the opportunity to be able to appear here today.

I have a statement I would like to submit for the record, but because much of the information in the statement has been previously covered by other witnesses, I would like to excerpt from my formal statement in terms of verbal presentation.

ASSEMBLYMAN BAER: Very good. We appreciate the testimony and we appreciate the excerpts.

MR. WUNDERLE: I am Robert E. Wunderle, Economist and Vice President of Public Affairs for the Pathmark Division of Supermarkets General Corporation. Pathmark is the largest dispenser of prescriptions in the New York metropolitan area. We operate 82 pharmacies in supermarkets and free-standing drug stores.

Pathmark strongly urges the adoption of legislation which would permit the advertising of prescription prices as well as legislation that would require the posting of prescription prices in pharmacies. To that end, we endorse A-3273 as proposed, and A-1228 with minor modification.

The basis for our support for these bills is quite simple; that is, the consumer's right to know.

The regulatory prohibition against advertising prescription prices exacts an unconscionable toll on the American public.

In July 1974, Pathmark introduced a senior citizens health plan, which, among other benefits, provided a 10 percent discount on prescription drugs for senior citizens. The existing regulation did not permit us to

advertise the fact that senior citizens could get a 10 percent discount on prescriptions from Pathmark. Instead, we were relegated to using the saccharine phraseology of "we offer a discount to senior citizens; ask our pharmacist for details."

Interestingly, Subsection (f) of Revised Statutes 45:14-12 permits extending discounts to senior citizens, but subsection (c) of that same regulation prohibits public disclosure of the amount of the discount.

Additionally, the New Jersey Medicaid Plan has critical financial problems and is considering a "co-payment" provision which would require medicaid recipients to pay 50 cents for prescriptions that heretofore cost them nothing. Pathmark cannot advertise that a medicaid prescription filled at one of our pharmacies costs the state less than the amount permitted under the law. Pathmark charges medicaid our "current retail price" which, 75 percent of the time, is below the $2.05 professional fee plus the wholesale cost as permitted by medicaid regulations.

Pathmark makes telephone disclosures of the price of various prescriptions, yet we are prohibited by the existing law from advertising that fact as well as listing phone numbers to call. Not only are we prohibited from advertising prices, but we are prohibited from encouraging consumers to shop for price.

As for arguments made against prescription advertising, I think our views very closely parallel that of Commissioner Annich. Therefore, I will not repeat them here.

To argue that advertising prescription drugs will encourage supermarkets and discount department stores to use prescription departments as loss leaders is to exhibit a gross misunderstanding of the margin structure in mass merchandise stores. Whereas an independent drug store may look at a 100 percent margin as standard and

a 200 percent margin as exceptional, supermarkets look at a 20 percent margin as standard and a 35 percent margin as exceptional.

Pathmark's interest in the prescription advertising and prescription price posting is not new. On September 6, 1972 Pathmark filed lawsuits in New York, New Jersey, and Connecticut seeking rulings that these states' legal prohibitions against the advertising of prescription prices were invalid. The results of our efforts were (1) a "consent order" in New Jersey to permit price posting, (2) a discontinuance in Connecticut after that state adopted a voluntary prescription posting statute, and (3) a termination of the litigation process since New York State adopted a mandatory prescription price posting statute. After incurring legal fees in excess of $125,000, Pathmark decided not to continue any of the lawsuits, and thus we stopped short of our ultimate goal.

In the deliberations over the consideration of permitting prescription price advertising and mandatory price posting, we do not have to rely on theoretical speculation on the probable effects of changes in the regulations. Currently, prescription advertising is permitted in 22 states. The most recent state to permit prescription advertising was Connecticut where the bill went into effect on May 12th, I believe.

Do not consumers in New Jersey have the same right to know the relative cost of prescriptions from various pharmacies? Your efforts can make the rights of New Jersey consumers a reality.

For the foregoing reasons,we urge your favorable approval of A-3273 as proposed. In addition, we urge your approval of A-1228, amended however to stipulate a minimum size for the in-store sign without restricting its maximum size.

I would like to make a couple of other comments based on previous testimony.

One, was an issue on the selection that is carried in chain pharmacies versus that carried in "neighborhood" pharmacies, the statement that chain pharmacies and particularly in supermarkets carry only 40 percent of the items which account for 65 percent of the volume. That is false. Our selection in any given market is equal, if not greater than, competitive stores with equal volume.

The second item on advertising cost and what it is likely to be for us as well as for independent pharmacies: I think it is totally a false issue because when we are talking about exorbitant and high advertising costs, we are talking about advertising to stimulate and create demand. Prescription price advertising is not intended to stimulate demand for any product; it is intended merely to post and note price.

Another item is: We do not use prescriptions as loss leaders. There is a very justifiable reason why independent pharmacies and neighborhood pharmacies have higher prices. They have higher operating costs. They offer many more services than we do. Our cost of the product, as was borne out by the gentleman from the Pharmaceutical Association is lower because of the quantities that we can buy in and because of the limited services we offer.

Another item: Some of the testimony this morning seemed to indicate that people are viewing the advent of advertising prescription prices with all the anticipation of the Four Horsemen of the Apocalypse and that we are going to have monopolies and we are going to have an anti-competitive market structure. I think the fact is that, number one, consumers are simply not just price shoppers. It is not a question of will Pathmark's or any other chain pharmacy's prices drive independents out of business. The question is: Doesn't the public have the right to

know how much they are paying for that additional service that is provided by a neighborhood pharmacy?

The other point is: We do indeed have anti-trust laws to prevent the monopoly from occurring which we are told is going to occur. It is not a question of the monopoly occurring overnight. Currently, chain pharmacies in New Jersey are outnumbered approximately four to one by independent neighborhood pharmacies. So we are not going to have a monopoly overnight. And if anti-competitive practices develop, there are federal laws, I believe, and certainly State laws to take care of any anti-trust problems that could conceivably result.

I think the last item I would like to address is the suggestion that was made that perhaps a commission be established to look into a peer-group review or something like that of unconscionable prices. I personally feel that that suggestion is a diversionary tactic to delay action on the proposals that are before us. I really don't feel in the final analysis that any court or the Legislature of this State is going to agree to a structure which, in effect, allows and licenses independent price-fixing.

Thank you.

(Mr. Wunderle's complete statement can be found beginning on page 22 X.)

ASSEMBLYMAN BAER: Thank you very much.

Do you have a question, Mr. Rys?

ASSEMBLYMAN RYS: Yes, if I may. With regard to the amendment you have suggested to 1228 in your statement, there is a little confusion in my mind. Can you describe that more fully?

MR. WUNDERLE: If I recall correctly, under 1228, the proposal says that pharmacies be required to post prescription prices in stores.

ASSEMBLYMAN RYS: No, we are talking about signs - minimum size.

MR. WUNDERLE: There is no stipulation in the proposal in terms of what the size of the signs should be or what the source of the signs should be. Our concern is that the Pharmacy Board may decide that an 8 1/2 by 11 sign with pica type is more than adequate. We think that would totally defeat the purpose of 1228. Therefore, we would suggest that 1228 be amended to state that the sign can be no smaller than whatever size you would propose, and no restriction be put on its maximum size. I believe the one that we use in New Jersey is 15 square feet.

ASSEMBLYMAN BAER: I wanted to ask a little further amplification on this point that you have referred to so far as the variety of selection.

I wasn't following the exact point on the sheet as you were reading it, so I haven't examined your precise wording. How did you describe it again?

MR. WUNDERLE: I said that our selection, the selection of prescription drugs that we offer, in any given market area is equal to if not greater than the selection in competitive stores of equal volume.

ASSEMBLYMAN BAER: What do you mean by competitive stores of equal volume?

MR. WUNDERLE: For example, if we have a store in Newark and there is another pharmacy across the street, I can tell you with very high assurance that we will have the same selection in our store that that pharmacy across the street will have if he writes approximately the same number of prescriptions per week that we do. The selection that we have in that store may be far different than the selection we would have in a Philadelphia store.

ASSEMBLYMAN BAER: Let me ask you this: You are talking about stores of equal volume. I am not sure

whether that means that you are saying that other stores that have high volume also have smaller amounts and that your selection is no smaller than that of other high-volume stores or whether you are saying that your selection is no smaller than that of stores that have lower volume too and you are setting this high volume store as a maximum; and you are suggesting that stores up to that volume,whether it is less or up to that size, have no less selection than you.

MR. WUNDERLE: Let me greatly simplify the statement. I am not playing on words in terms of one of our pharmacies versus another chain pharmacy that does a tremendous number of prescriptions. What I am saying is that we offer as great a selection as any other pharmacy in a direct competitive basis, whether that pharmacy be a chain pharmacy or an independent pharmacy.

ASSEMBLYMAN BAER: I see. How would one measure the selection that a given store would offer? What objective measures are there to determine this?

MR. WUNDERLE: One of the easiest ways would be to count the number of items. What is our indication? Did we run a survey? No, we didn't. Our indication of this is that we know, for example, in different towns physicians will have a tendency to prescribe one drug in favor of another. There is a certain mix that physicians in one town may favor over a mix in another town.

We know, for example, that when a prescription comes to us, if we don't have that product in stock in the store, we go through exactly the same process that an independent pharmacy does. We tell the bearer of the prescription that we do not have it in stock, if we do not have it in stock, and we will get the product for her and it may take x number of days to get it. If she says, "Forget it; no, I don't want it," then we don't get it. If she says, "Please get it," then we will proceed to get it. If we

have a second request for that same product and the woman still says, "No, I don't want it because it is going to take two days to get it," we go out and stock that product because if we have had two requests in a row, we can assume that there will be a third.

The other thing we know is that our pharmacists -- We employ more than a hundred pharmacists. They went to pharmacy school. They grew up in the same neighborhoods as many of the pharmacists that work in independent stores. They talk to each other. Then know what the relative selections are. We know from the products that are asked for in our stores, the products that we don't have and have to order that are beyond our current stocking in a given situation, and we also know by talking to pharmacists who work for independent neighborhood pharmacies.

ASSEMBLYMAN BAER: You are familiar with the arguments so far as the contrast in services ---

MR. WUNDERLE: Certainly.

ASSEMBLYMAN BAER: (Continuing) --- and the concern that has been expressed as to whether stores providing these services would be less able to do that, whether these services would dwindle in competition.

You indicated that your lower prices were partly due to not as full services. What are the services that you do not provide that have the largest impact in terms of your savings?

MR. WUNDERLE: Let me put that in perspective. Our lower prices are due to perhaps our buying power, number one; number two, our economies of operation ---

ASSEMBLYMAN BAER: That is not what I am asking.

MR. WUNDERLE: I know that, but I am putting this back in perspective. I am not saying that our primary cost advantage is because of lack of services.

ASSEMBLYMAN BAER: I realize there are other things

that enable you to do this.

MR. WUNDERLE: Well, those are the main ones. I think the most obvious one is delivery. We don't deliver. We don't pick up prescriptions; we don't deliver prescriptions.

ASSEMBLYMAN BAER: If, in the balance, legislation were to permit advertising, but require you to provide some of these services - let's say delivery and let's say a guaranteed breadth of selection - would you favor such legislation? I know it is hard to say precisely without seeing it. But what would be your feeling about such legislation?

MR. WUNDERLE: It is hard to say precisely since I don't know what the nature of the proposal would be. I would say any competitive constraint that is put on across the industry we could live with as well as other competitors, because what in effect it is is a tax on the cost of operation where someone says that a service is for the "public good," therefore, you must perform this, and it is going to cost you more. It affects our competitors the same as it affects us.

ASSEMBLYMAN BAER: You are dealing with half of my question, which is: How would you feel if you had to provide some of these additional services? But what I am asking you is, if legislation were to also permit advertising and require you to provide these services, would you be inclined to favor that legislation in the balance of the two?

MR. WUNDERLE: I doubt it. The reason that I doubt it is that we don't offer those services right now because we feel there is a very significant part of the public, a very significant segment of consumers, who don't want those services nor do they want to pay the overhead for carrying those services.

ASSEMBLYMAN BAER: Well, for instance, delivery could be an additional charge. It doesn't necessarily have to be carried at the expense of those who don't wish delivery.

MR. WUNDERLE: That makes an assumption of the volume of deliveries that a particular store makes. In other words, you find out at the end of the year if the number of deliveries you made covers the cost of renting your car and the salary of the man to drive your delivery car. So,in coming up with your rate structure, you are going to have to prorate that on the first prescription you fill.

ASSEMBLYMAN BAER: I understand. I have no more questions.

ASSEMBLYPERSON CURRAN: Mr. Wunderle, what about the service involved in calling doctors and discussing prescriptions?

MR. WUNDERLE: Certainly we do that.

ASSEMBLYPERSON CURRAN: You do it, but do you do it with any frequency or any regularity? Is there any established standard on it?

MR. WUNDERLE: One thing has to be cleared up. You talk about professionalism of pharmacists. I think our pharmacists are equally as professional as any other pharmacists and they have good reason to be far more professional, if there is such a term as being far more professional. The Pharmacy Board would not like to hear that. The reason is that their job is only to dispense prescriptions. They are not the advertising managers of the store. They don't order Kleenex, tobacoo, radios, and kodak film. They don't stock. They don't manage labor. They don't handle the sanitation. Their job is solely and simply to dispense prescriptions and fill prescriptions and check their accuracy. So we perform the same professional service and call doctors with the same regularity as any independent pharmacist does.

ASSEMBLYPERSON CURRAN: That is interesting; the whole question of professionalism is interesting. I can

appreciate certainly your expertise here today. You, though, are not a pharmacist.

MR. WUNDERLE: No.

ASSEMBLYPERSON CURRAN: Who is in charge of pharmacists for Pathmark?

MR. WUNDERLE: The Vice President of our Drug Division is a pharmacist. The gentleman in charge of pharmacy operations is a pharmacist. Our Field Supervisors are all pharmacists. So from the top all the way down to the man who fills the prescription, each man has a pharmacy degree.

ASSEMBLYPERSON CURRAN: Are any of those men here today?

MR. WUNDERLE: No, they are not.

ASSEMBLYPERSON CURRAN: I am just interested in why Pathmark would make the obvious distinction of sending someone in public affairs rather than a pharmacist.

MR. WUNDERLE: It is their job to supervise pharmacists and my job to come to meetings.

ASSEMBLYPERSON CURRAN: I can appreciate that.

MR. WUNDERLE: The Field Supervisor was here with me yesterday.

ASSEMBLYPERSON CURRAN: Okay. That's a valid reason.

MR. WUNDERLE: And he will be returning here at two o'clock looking for me and I hope someone will tell him that I have already been on and left. He had to go to some stores this morning and he will be back this afternoon, seriously.

ASSEMBLYPERSON CURRAN: Do you know officially or unofficially whether Pathmark has any quota system?

MR. WUNDERLE: Quota system?

ASSEMBLYPERSON CURRAN: I am trying to get all the facts we keep hearing in the halls out on the table and down on the record. Do you know officially or unofficially whether Pathmark has any quota system for their pharmacists?

ASSEMBLYMAN BAER: Quota on what?

ASSEMBLYPERSON CURRAN: Prescriptions - per day or per hour.

MR. WUNDERLE: Categorically, no. It is a ludicrous concept that you have a quota system since we don't go out and stimulate the demand for prescriptions. If we could go out and make people sick and make sure that those sick people bring their prescriptions to the store, then it is reasonable to have a quota system. Since we don't generate the demand for prescriptions, we can't expect a quota in terms of filling them for any given time.

ASSEMBLYPERSON CURRAN: I can appreciate the fact that you certainly are not using part of your advertising budget for some sort of germ warfare to make people in the area sick. But let us give some credence to the fact that you wouldn't build a store unless you thought there would be people in that area who were hungry. I know you don't make them hungry either. But you assume there are hungry people and they are going to want x amount of food. I would assume that you would look at your records, being an economist, and decide where it would be feasible to put a pharmacy and where it wouldn't. I would assume there would be areas where you might decide not to do this.

Given that idea, if you somehow in regard to these statistics estimated - and I realize it is only an estimate - that perhaps you would have a possible market of, say, 500 prescriptions a day, just because of the number of people who go in and out of that store, I would think then you would have to translate this into man hours in regard to how many prescriptions a man could adequately fill in that time. I was wondering in that regard if there is any quota.

MR. WUNDERLE: No. As any gentleman here can tell you, when you open up a store, you put in your

initial staffing of people and you then adjust your staffing. If there is too much work for your initial staffing, you bring in more people. If there is too little work for your initial staffing, you lay people off.

ASSEMBLYPERSON CURRAN: To get around the issue the other way, would you know about how many prescriptions an hour the average pharmacist in your average pharmacy would fill?

MR. WUNDERLE: No.

ASSEMBLYPERSON CURRAN: Do you think there are any statistics on that?

MR. WUNDERLE: Are there statistics?

ASSEMBLYPERSON CURRAN: What I am saying is: I can appreciate you may not have the figure at hand. But are there statistics in your marketing operations ---

MR. WUNDERLE: I would assume there are those statistics. I would assume we have them.

ASSEMBLYPERSON CURRAN: If you do, we would appreciate, I think, copies of anything like that that you might have because this is one area, about which we hear an enormous amount of complaints.

MR. WUNDERLE: May I ask: What is the nature of the complaint?

ASSEMBLYPERSON CURRAN: The nature of the complaint would be that a man is, let's say, required to fill 15 prescriptions an hour or 20 prescriptions an hour as opposed to a community pharmacy where he may perhaps, basically because of the delivery of services, be able better to adjust his time.

MR. WUNDERLE: I would like to very seriously challenge the entire i d e a that he is required to fill x number per hour. Once again, we don't stimulate the demand for the prescriptions.

ASSEMBLYPERSON CURRAN: I can understand that.

MR. WUNDERLE: So, therefore, how can we require him to do that? We have to have a pharmacist on duty when

the pharmacy is open. We can't control the number of prescriptions that come in.

ASSEMBLYPERSON CURRAN: I am sure that is true.

MR. WUNDERLE: As I say, if the data is available, which I would assume that it is, I will supply it to the Committee; it will be no problem at all. I would like to further add that this man does nothing, literally nothing, aside from filling prescriptions.

ASSEMBLYPERSON CURRAN: I am sure that is true.

MR. WUNDERLE: If the comparison was between one of our pharmacists who fills x number of prescriptions and the independent pharmacist who does x number, our man doesn't do the things that that independent pharmacist does either, such as, check on his labor, check on his sanitation, etc.

ASSEMBLYPERSON CURRAN: That is why we are trying to get something for a basis of comparison.

MR. WUNDERLE: I would just like to make that clear.

ASSEMBLYPERSON CURRAN: I can appreciate that, but we are just trying to get something for a basis of comparison and I think that would help all of us.

ASSEMBLYMAN BAER: I don't want to overly focus on this thing that Mrs. Curran has been talking about. I guess, as I see it, the question would be: What are the pressures on a person who is working as a full-time pharmacist in a supermarket operation, let's say, with more than enough work to do? What are the pressures in terms of productivity to begin with? Secondly, are, in fact, the pressures of productivity in this type of operation any greater than the pressures of productivity that presumably also are present in other types of operations? I am interested in your view on that.

MR. WUNDERLE: I personally would argue the pressures on productivity ---

ASSEMBLYMAN BAER: There is no profit-making operation in which there aren't some pressures of productivity.

MR. WUNDERLE: That is a very good point and one I would like to reflect on. I would say that there are far fewer pressures on productivity from the standpoint of the individual pharmacist in our store than in an independent store. The pharmacist in our store is a salaried worker. He does not have to worry about the financial health of Pathmark or that pharmacy department to maintain his job or his salary. He is there to dispense prescriptions and he also is represented by a union. So it is not the sort of thing where a big corporation is telling this man to go out and drum up prescriptions or whatever. The man is there as a service, represented by a union. His pressures are to perform his job with the professionalism which he is hired for, and he receives a salary for that.

ASSEMBLYMAN BAER: By the way, what union represents the pharmacists?

MR. WUNDERLE: I can get you the name of that. I don't know that.

ASSEMBLYMAN BAER: I would suggest, Mrs. Curran, if you were to communicate with the union, you would get a response that you could feel would be a pretty arm's length response on this matter.

ASSEMBLYPERSON CURRAN: That is a good point. I would like to ask --- and I apologize.

ASSEMBLYMAN BAER: Don't apologize.

ASSEMBLYPERSON CURRAN: I had to go out to accept a call. I know you were talking about inventory when I came back in the room. I don't want to belabor the question if you feel it has already been adequately covered in the testimony.

ASSEMBLYMAN BAER: We went into it.

ASSEMBLYPERSON CURRAN: Completely?

ASSEMBLYMAN BAER: I don't know how completely, but we went into it.

ASSEMBLYMAN RYS: I have one question: Isn't it

a fact that the percentage of discounts that you receive from major drug companies generates prescription business in your stores? It is a pretty rough question, isn't it?

MR. WUNDERLE: No. I think it is a back-door question.

ASSEMBLYMAN RYS: No, it isn't.

MR. WUNDERLE: The prices that we offer generate more prescriptions. One of the very significant reasons why we have the prices that we offer is because of the quantities that we buy in. But to say that the discounts that we get from manufacturers for quantity purchases generates more people coming into our store, there could be the implication there that we are saving a little out of that ourselves too.

ASSEMBLYMAN RYS: I have no doubt of that. But I assume a good business organization when they are receiving discounts will lower their prices.

MR. WUNDERLE: Yes, sir. Based on that assumption, yes, sir.

ASSEMBLYMAN RYS: I had one other question. I was going to bring in the situation of the whole story, but I will skip that.

MR. WUNDERLE: The loss leading?

ASSEMBLYMAN RYS: Yes, but I will skip that.

MR. WUNDERLE: I would be happy to address it.

ASSEMBLYMAN RYS: No. I think you answered the question I had.

ASSEMBLYMAN BAER: I want to thank you for coming here and testifying today and also for waiting through yesterday. Your testimony gives us additional perspective on this whole matter.

The next witness will be Mr. Kritz.

N O R M A N K R I T Z: My name is Norman Kritz, President of the Camden-Gloucester County Pharmaceutical Society. For three years, I was the pharmaceutical consultant to the Camden County Methadone Clinic. I now

teach a course in respect for drugs in the Cherry Hill School system and at St. Joseph's High School in Camden. It is officially accepted by the Camden Diocese. It is recommended by the New Jersey Department of Education. It has also been accepted as a model program by HEW, Health, Education and Welfare, at the federal level.

I have been invited by the federal government to a conference to help develop a national policy for primary drug abuse protection, which I will attend next week at New Haven, Connecticut.

I would now like to make a statement taken from one of the many articles in my presentation, all of which I hope will be entered in the official records. The article is a reprint from the New England Journal of Medicine in reference to advertising.

Television, a most powerful communication medium, should be used as an integral part of a plan designed to deliver better health care. You might say I represent all consumers from birth to death. I represent the future of the health of this state and nation.

Because of my deep concern and due to the fact that I teach a course in respect for drugs in three high schools in Camden County, the Attorney General, Mr. William Hyland, has asked me to comment on Assembly Bill A 1228. The comments may cover other bills on price posting and advertising of prescriptions. I cannot separate my statements.

First of all, I want to say that I am unequivocally in favor of lowering the prices of all pharmaceuticals. In this inflationary world in which we must exist, there is no question that the consumer is bearing an over-loading burden. However, many questions appear in my mind as to effect and cause. Just what effect would there be and what caused it? We live in a drug-oriented society. Will the A's beat the B's? Will Sominex produce that

much-needed sleep? Is Compox the panacea for all tension-ridden persons? Try it; you'll like it. These are the ploys of Madison Avenue. They have made drugs household words. You talk about drugs like you talk about potatoes, hamburgers, charcoal brickets. Send your son down to the store to pick up some Coca Cola and while you are there, get some Contact. Yes, get Contact for your cold, but what about your high blood pressure, your glaucoma, your heart disease? You cured your cold, but the rest of you ended up in the hospital. Sominex, Compoz - how did they affect your glaucoma? Did you hallucinate from them? Alka-Seltzer - did the aspirin in it perforate your gut? Did it neutralize your gout medicine? Did it make your blood thinner because of the Coumadin you were taking and cause you to hemorrhage?

These products I mentioned are the "simple" every-day "harmless" home remedies. But what about the legend drugs? Yes, what about the rest of the dangerous drugs that require prescriptions? It is ironic. Today we have ten million alcoholics in the country. How many developed before the ban on advertising? Today we have fifty, maybe one hundred million smokers, who knows. But all of a sudden there is no more advertising allowed. How many times in our lives must we see that lock put on the empty barn? How long will it take before our children equate commodities with advertised drugs? How long will it take before our children lose all respect for prescriptions when they see ads: "Darvon Comp 65 ($3.99 for 50); Valium 5 mg. ($7.19 for 100); and our special of the week, 100 Quaalude, 300 mg., for only $7.95 -- this week only. Save now for next week it goes back up to $9.50."

Just how dangerous can these drugs be if they are so freely advertised and promoted? Must we add to a world of smoking, drinking and pill-popping? Where is our love of mankind? Does everything covering health and

life, itself, have a price?

New Jersey is the only state in this country with mandatory patient profile record-keeping. Last month, at 12 Midnight on a Tuesday night, I was attending a seminar on arteriosclerosis. This mandatory education is a requirement in this State to maintain my license. So I learned you cannot mix Atromid S with Coumadin. But what about you, Mr. Bear? Suppose you bought your Atromid S two blocks away from me and saved a dollar, but you get your Coumadin from me, and you saved another dollar. You are lucky. You saved two dollars and you didn't even have to drive five or ten miles. So you saved on gas too. But you were too embarrassed to tell me about the Atromid S you take. So on your epitaph it will read: "Byron M. Baer - he saved two dollars and bled to death."

How can I be sure when I dispense a prescription if my patients are running from one price to another? As members of the Assembly, your job is to protect and represent the people of the State of New Jersey. My job is to deliver the best pharmaceutical care I can. You have to let me protect my patients. You cannot take that away from them.

In direct rebuttal to Mrs. Annich, when she spoke about patient profile-keeping, I would like to add for the record a researched article by Philadelphia Magazine, August, 1974, entitled, "Bitter Pill:"

(Reading) "Living in New Jersey is better for your health. No one appreciates that more than Mike Spiduro, a Cherry Hill bartender who suffered a heart attack in 1972. Spiduro's cardiologist prescribed Coumadin, a potent blood thinner. For bursitis pain, his internist prescribed an aspirin compound. If Spiduro had lived in Philadelphia, or anywhere other than the Garden State, the interaction of the two drugs might have killed him.

"Coumadin and aspirin can cause serious hemorrhage. Cherry Hill pharmacist Norman J. Kritz kept this from happening to Spiduro because he is required by New Jersey law to keep up-to-date patient patient profile records on the medical history of all prescription customers. When Spiduro arrived to have the prescription for bursitis filled, Kritz pulled out his profile record and knew immediately that he was taking Coumadin.

"Last October, New Jersey became the first state to require pharmacists to maintain profile records. In an era when three medical problems usually mean a trio of specialists, it requires time and expertise to spot potentially dangerous combinations. Only your pharmacist knows for sure. In Pennsylvania, the pharmacist knows, 'only on his own initiative,' according to Arnon Lear, executive director of the Pennsylvania Pharmaceutical Association. There is no Pennsylvania law requiring pharmacies to maintain patient profiles, although increasing numbers of them are doing so on their own.

"If Pennsylvania is to have a mandatory profile system, the decision has to come from the Pennsylvania State Board of Pharmacy, whose chairman is Dr. Sol Turnoff. 'The question,' says Turnoff, 'is whether the profiles do what they are supposed to do.' Turnoff told us the question has been under study for some two years, but he expressed the feeling that maintaining patient profiles might take too much of druggists' time. His concern seems very touching, until you remember that Turnoff is supposed to be looking after the welfare of the public, not the druggists.

"Turnoff may be a hard man to convince. His own daughter was hospitalized not long ago when drug interaction caused her blood pressure to drop suddenly. Her pharmacist had not been required to record the drugs nor the circumstances."

I might add that Miss Susan Davidoff, Supervisor of the Camden County Methadone Clinic, has written a letter in direct opposition to prescription price posting or advertising since she feels that it would only lead to more drug abuse. I would like to read that letter now: (Reading)

"Dear Mr. Kritz:

"Working in the field of drug abuse for three years, the last two being spent as the Clinic Supervisor of the Camden County Drug Abuse Clinic, I consider it imperative that I respond to the question of whether or not the legislators should permit the advertising and pricing of legend drugs.

"I do not represent the pharmaceutical companies, cut-rate pharmacies, the advertising industry or 'script doctors' but rather the expertise of professionals dealing with the drug abuse problem in our society today. As such, I am most emphatically against the advertising of barbiturates, amphetamines, psychotropics and analgesics. The possible ramifications of advertising these types of drugs is increased drug activity.

"How can we hope to instill in people reverence and respect for the power of these drugs, curative as well as destructive, if we allow advertising to promote them as if they were supermarket specials.

"Once only a small subculture of drug users were familiar with these products; with advertising, this will no longer be true.

"Will there be limits on the content of the advertising? Or will they eventually follow the example of patent medicines, encouraging self-diagnosis and self-medication? Will doctors merely be the waiters and waitresses standing by for orders from the public that wants to take advantage of a special mind-altering drug or drugs?

"We have set limits on the advertising of cigarettes and whiskey, legal nonprescription drugs, in the hopes that it will discourage use. It is rather paradoxical that we would consider opening a yet unopened Pandora's box in the case of prescription drugs and their advertisement.

"Sincerely yours, Susan Davidoff, MSW Clinic Supervisor."

That is my statement. Thank you. (See page 20 X.)

ASSEMBLYMAN BAER: Are there any questions?

ASSEMBLYMAN RYS: I have one question pertaining to the writer of the last letter, Susan Davidoff. Is she with the State of New Jersey?

MR. KRITZ: Yes, she is.

(Discussion off the record.)

ASSEMBLYPERSON CURRAN: I think that was a very good statement. I am glad that Mr. Kritz took the time to come up and talk to us about this today because I think this is another dimension to the whole question of advertising which is certainly as valid as the other questions, but perhaps in a way not as practical. So it is not something we hear as frequently and I appreciate it very much.

ASSEMBLYMAN BAER: I would like to ask a question. In terms of the drug interactions that you review with the patient'profile method, how many combinations of drug interactions are there that can have fatal consequences? Would you have a rough idea?

MR. KRITZ: How many?

ASSEMBLYMAN BAER: Yes.

MR. KRITZ: Let me take you through a patient profile and you can see from my questioning what the possible ramifications could be.

ASSEMBLYMAN BAER: I am trying to get ---

MR. KRITZ: A figure?

ASSEMBLYMAN BAER: Yes.

MR. KRITZ: Aspirin could be fatal to any person who is taking a blood thinner, any person who has an ulcer.

ASSEMBLYMAN BAER: You have already referred to that. I am asking how many combinations are there that can have fatal consequences?

MR. KRITZ: Thousands. Here is a booklet on drug interactions as utilized by the Philadelphia College of Pharmacy. You have my own interaction report which I have given you. How often does it occur in the daily practice of pharmacy in my pharmacy? I don't think there is a day that goes by where we don't pick up a drug interaction or reaction - not a day.

ASSEMBLYMAN BAER: Of a fatal nature?

MR. KRITZ: That could be fatal, yes - mainly because we feel that any prescription is guilty until proven innocent. The mere fact that the physician wrote it does not give me leave to fill it. I have to be assured in my own mind that that patient can take it and I have to know what his medical background is, his medical history, and what the dosage is. So, before I fill it, I have to go through a complete regimen with that patient.

ASSEMBLYMAN BAER: How adequate is this book?

MR. KRITZ: That is one of many that we keep at our pharmacy. It is considered by the Dean of Pharmacy at the Philadelphia College of Pharmacy to be the book of choice for drug interaction.

ASSEMBLYMAN BAER: So this would contain most of the drugs to which you would look for that type of interaction, except for new products coming out.

MR. KRITZ: That is right. There is also a book that was recently published by Eric Martin, called "Hazards of Medication," a $29 job, a lot more money than that one, which covers many more interactions. And his opening statement in that book is that last year alone

there were 1,500,000 entrances into hospitals as a direct result of either drug reaction or interaction - 1,500,000.

ASSEMBLYMAN BAER: And some of them occur with patients that are already in hospitals also.

MR. KRITZ: That is correct.

ASSEMBLYMAN BAER: This is, "Drug Interactions: Clinical Significance of Drugs, Drug Interactions and Drug Effects, and Clinical Laboratory Results," Phillip D. Hanston, Assistant Professor of Clinical Pharmacy, published by Lee and Febiger, 1971, Philadelphia.

Could you give me some idea as to what the cost on the average is to a pharmacist per prescription to maintain the patient profile system?

MR. KRITZ: I have never figured out the cost, mainly because I have been keeping patient profiles since 1957, long before it became mandatory. It doesn't enter into my costs.

ASSEMBLYMAN BAER: Where would you suggest I get that information because obviously there is time and effort expended, and I am interested.

MR. KRITZ: I imagine Mr. Geser could possibly provide that figure. Cost factors have never played a major role in my area. I spend 20 to 25 hours a week teaching in drug abuse and my pharmacist does an awful lot of work for me.

ASSEMBLYMAN BAER: Could you refer this to Mr. Geser and see if he could give us that information?

MR. GESER: Before I do that, since you have called on me, I would like to point out, if I can, that the drug interaction that Norman mentioned, dealing with Aspirin and Coumadin, is the kind of thing that the Pathmark testimony glossed over because it is not the kind of things required by the regulation. The regulation relates to prescription drugs only. The fact that many pharmacists, such as Norman Kritz, can pick up and prevent the interaction

between a drug which requires a prescription sale and a drug which does not require a prescription is over and above the very minimum that the regulation requires and it is the kind of thing that the Pathmark testimony just completely glossed over and, frankly, ignored, by their choice, I think.

The direct answer to your question is: We had one of our people who operates three or four pharmacies look into what it costs per prescription and it was his estimate at that time - that was in 1973 or thereabouts when the regulations went into effect - that it costs less than ten cents per prescription to do it properly.

ASSEMBLYMAN BAER: I see.

MR. KRITZ: Excuse me, Mr. Baer. I might like to add something Mr. Geser left out. I think the fact I can pick that up whereas a Pathmark pharmacist couldn't is because I have direct contact with the patient.

A pharmacist in my pharmacy must deal with that patient when he presents that prescription. It is not just handed out, collected for, and good-bye. He is told how to use it, when to use it, what possible ramifications could occur if he takes it with food or without food. Should he take it in the sun out of the sun - with milk, without milk? All these things must be entered into and explained to the patient before that prescription is delivered; otherwise, we will not deliver a prescription.

ASSEMBLYMAN BAER: What occurs to me,and the reason for some of these questions, is that obviously many persons that buy prescription drugs and non-prescription drugs today, do not all buy them from the same location. To the extent to which people do, this system has value. To the extent to which they do not, it works to a lesser degree. If it does have value, it seems to me, one of the questions to address is: How can it work more efficiently?

I don't think the way to make it work more efficiently is to try to force people to be confined to a single pharmacy. I think we also have to explore other possibilities, such as, labelling where one drug creates a problem, particularly with a whole spectrum of other drugs. Maybe that is the one that should be labelled. I don't know whether this is practical, but it is certainly something I would like to see explored. I think we also have to consider the possibility as to whether there is any way, with the use of sophisticated data-processing resources that are available today, we can correlate information coming from different pharmacies.

I think if this patient profile system is a valuable one and an important one for protecting health, that these are questions that can have a far more fundamental effect in terms of protecting people's health than the question of advertising, itself. If this is true, there should be concern about the percentage of patients who don't always buy drugs at the same store.

Without getting into the other questions on advertising, for the moment, which also are very profound questions, I think, since you have focussed on this patient profile question and its importance, it is very hard to look at it without looking at these aspects I mentioned, in view of the fact you point out that it sometimes is a life and death matter. Even if that is rare and even if most of the interactions are more a matter of discomfort or temporary distress of some degree, I am very interested to know what thought has been given to exploring these other means that I have mentioned and perhaps others that I have never even thought of as a means of making this more effective.

MR. KRITZ: In the area of drug abuse, which is mainly where I work, this past Wednesday I met with members of the Medical Society and Osteopathic Society, Methadone Clinic and the Attorney General's Office, in reference to feeding information into one central area of all patients and physicians who are writing controlled-type medication.

If you remember in Miss Davidoff's letter, she mentioned the word "script" doctor. Do you know what script doctor refers to?

ASSEMBLYMAN BAER: May I interrupt you for a moment.

(Discussion off the Record)

MR. KRITZ: There will be a central area where all this information will be fed. This is designed to stop the script doctor, the guy who is writing prescriptions for the user-abuser - I say user and abuser because there are many adults who are not considered drug abusers who go to a doctor, tell him what they want, pay the fee, and, without an examination, come out with that prescription. The narcotic addict is such a person also. This is designed to correlate all that material and feed this material back to an enforcement agency.

So in just the drug abuse area, yes, we are attempting to do that.

As for the patient profile, Mr. Paul Braverman will speak this afternoon in depth on that, so I have just been informed. As I said, my main area of expertise is in drug abuse.

MR. GESER: He will speak on profile records in an electronic data-process system that is being developed for the Newark Medicaid Waver Program.

ASSEMBLYMAN BAER: We will get into that this afternoon. I have no further questions.

MR. KRITZ: Thank you very much.

ASSEMBLYMAN BAER: I want to thank you very much for your testimony. It has been very helpful.

We will recess now and return in an hour.

(Recess for Lunch)

AFTERNOON SESSION

ASSEMBLYMAN BAER: The afternoon session of the Commerce, Industry and Professions Committee public hearing will come to order. We have five witnesses scheduled to speak this afternoon, Mr. Braverman, Mr. Miskiv, Mr. Nawrocki, Mr. Brockman, and Mr. Feldman. If anyone else wishes to testify before the committee, please give your name to our committee aide. The first witness will be Mr. Braverman.

P A U L B R A V E R M A N: Thank you, Mr. Chairman. I am a practicing community pharmacist in the City of Newark. I am the President-elect of the Essex County Pharmaceutical Society and Secretary-Treasurer of the Newark Metropolitan Pharmacy Foundation. In the latter capacity, I have been at work over the past two and a half years with the State of New Jersey, the federal government, and the City of Newark in trying to implement a program of delivery of health care services in the City of Newark. It formerly was known as the Newark Medicaid Waiver Plan and the Newark Comprehensive Health Services Plan. It now, I believe, is officially known as the New Jersey Health Services Plan, Incorporated, a nonprofit corporation which is about to enter into a contract with the Department of Institutions and Agencies to provide health care services to the medically indigent in Newark and, potentially, to form an HMO to service 350,000 out of Newark's 385,000 people.

In the two and a half years that I have attended meetings of this organization and have met with representatives of the federal, state, and local governments, the federal government, through representatives of the Health, Education and Welfare Committee, has insisted on one thing: that the pharmacists of Newark who would be providing the service for this health care delivery program provide complete pharmaceutical services and that

a contract be entered into so that there would be a manner of enforcing this provision of services. One of the prime aspects of delivery of pharmaceutical services insisted upon by them is that each of us maintain, in some form, drug profile records of each patient connected with our particular pharmacy.

At the time we discussed with them that many of the stores have a manual system whereby, when a prescription comes into the store, through handwriting, we enter the prescription onto a drug profile card similar to this one. (Displays card.) This one has a carbon copy. I give the patient a receipt, and I have the carbon copy.

In order to more fully provide a program that would best serve the needs of the people of the City of Newark, and to try to obtain better cost benefits, we have been examining the possibility of computerizing the entire system for the City of Newark. There are, of course, both legal and medical problems attendant with the use of computers. We have contacted, in Hackensack, Bergen County, an organization known as Electronic Accounting Systems Incorporated which is prepared at this time to endeavor to provide such a system for the plan. But, at this moment, we use a manual system.

You gentlemen are now looking at an anonymous patient's card. On the left-hand side of the card there is the word "Idiosyncrasies." You will find under that that it was reported that both patients, the husband and wife, have colitis. You will find that in February of 1974, Dr. Kline, who is an internist, was treating this patient with a product called Azulfidine, and we were providing a product called Cortenema for the wife. If you will look at the bottom of the card, you will find that there was a prescription from a Dr. Merritt calling for Thymol to be dissolved in

a liquid. On that day, the wife not only brought me that prescription, but also one for a drug called Synthroid. I did not fill that prescription for her, because, on checking that drug, I found that the drug can cause diarrhea. In a patient who has colitis, diarrhea is the worst thing that can happen. I immediately called the dermatologist, Dr. Merritt, who called me back at 5 o'clock in the afternoon. I informed the doctor of my findings, and he agreed that this drug should not have been prescribed. I called the patient and explained that she would not be able to receive that tablet. She asked, "Why?" and I explained why. She told me that earlier in the summer she had had another prescription for the same drug, and, since she thought it was a simple, inexpensive little thing, she took it to the Pathmark store that lies between her home and the doctor's office. The doctor's office is in Livingston, and she lives in the Ivy Hills section of Newark. In between, in South Orange, there is a Pathmark supermarket that has a pharmacy department. She had the prescription filled there, she took it, and the pharmacist did not ask her anything, according to this woman.

In addition, I have a record here of one of the problems that I have encountered, and I think this is what I fear most. You can see that I have marked this record in red. That means, "Watch out." The patients r e a d i l y mix doctors and medication. They reported that they had no allergies, and then I received a prescription for an allergy. This came about because this woman, who is from India, went to an obstetrician-gynocologist with a rash that appeared on her upper left arm and then went to an endocrinologist in Livingston for a prescription because she was infertile, and she wanted to have a baby. She came in with a

prescription for a cortisone drug and a prescription for fertility. I refused to fill both prescriptions and contacted both doctors. The endocrinologist immediately told me, "Do not fill that prescription until the other medication has been used and another week has elapsed." When I questioned the husband, he said to me, "We notified both doctors, and both doctors were aware of it." When I spoke to the endocrinologist, he informed me that they were not aware of the situation.

I have here another profile card for a man who had a heart attack. Starting in July of 1974 and continuing to May 21, 1975, we were giving this man medication for his hypertension and heart attack. His wife came into the store and asked us for a bottle of Neo-Synephrine 1% solution drops, because he had a stuffed nose. We did not give it to her but immediately called their physician who is located in the Ivy Hills section and notified him of her request. The physician said, "Do not give that patient the 1% Neo-Synephrine. Give her a bottle of 1¼% Neo-Synephrine." If you look at a bottle of 1¼% Neo-Synephrine, you will find that it is marked for children.

I would like to tell you a true story. I think you will all remember that last September there was the Muhammad Ali-George Foreman fight in Zaire. In Maplewood there is a young man, a sound technician, who was going to be sent to Zaire to cover the fight. In the beginning of September, I was called by Dr. W who asked me, "What is the name of the drug used in malaria? It's on the tip of my tongue, but I just cannot think of it." I asked, "Is Aralen the one you're thinking of?" "That's it," he said, "Mr. X is going to Zaire for the Ali-Foreman fight. Give him enough medication. Thank you." With that, he hung up.

I checked a number of books, Facts and Comparisons, U. S. Dispensatory, the package insert that comes with the preparation, and a number of other sources but could not find the necessary information. Who was I to call to get that information? Who in the Essex County area possessed it? I decided to try the College of Medicine and Dentistry. When the operator asked to whom I wished to speak, I did not know who would have the information, so I asked to speak to the Dean. Dr. Wilson, the Assistant Dean, answered the phone call, and I told him about my problem. He replied that, unfortunately, he was not a parasitologist, nor was anyone at the College of Medicine. He offered two alternatives: The School of Public Health Service at Columbia University had received grants for public health work in tropical Africa, and at Cornell Medical School was one of America's leading parasitologists. After thanking Dr. Wilson, I called Cornell Medical School to speak to the doctor. He was out of the city. I asked for his associate and was informed that he had left the hospital but could be reached at his private office. I called and spoke to him and told him my story. Very graciously I was told the latest information on the use of this drug for malaria and was able to give to the patient the prescription. After two intermittant hours of making phone calls and explaining the situation, I was in the position of being able to properly fill the prescription. I priced the prescription at the cost of the medication plus my professional fee plus $1 for phone calls I had made. My question is this: What should I really have charged? If this had been a third party prescription through one of the insurance carriers or through the Department of Institutions and Agencies, Medicaid, who would have paid for my professional services?

I have some other examples here, and each one indicates a similar situation that has occurred. I wish I could have been here this morning, but I spent two hours this morning on this alone in my community pharmacy. I would, therefore, like to earnestly recommend that, before we go into some of the things that have been proposed, we carefully weigh all of the things that might logically follow when people get prescriptions from a number of sources and no one has any idea of what they are taking or what the interaction might be.

ASSEMBLYMAN BAER: The example that you gave interests me, because it certainly shows a very commendable and conscientious effort. I am not sure if you are suggesting that all low-volume pharmacies would produce such an effort, that this type of effort comes from some local pharmacies but not all, that there is, in fact, a major difference between types of pharmacy operations as you see it, that all pharmacies should be required to make this type of effort, that standards regulating this should be enforced, or that pharmacies that don't do this should be put out of business. Could you explain a little more fully what your thinking is in regard to this example and why it is relevant to us today?

MR. BRAVERMAN: My thinking is that, number one, a pharmacist is a professional and that, as a professional, it is his obligation to perform in the best possible manner for the benefit of those whom he serves. Unfortunately, I cannot speak for all pharmacists. By the same token, I doubt if there is a lawyer who could speak for all lawyers or a doctor who could speak for all doctors. To quote that old cliche, "There are bad apples in every barrel." However, where there is a situation where the pharmacist has no

contact with the public---

Let me go to something else for a moment. In our store, we have had students and interns at work, and our arrangement has been very amicable. They have gone to work, and they have come back to visit. Next week I am going to participate in the Rutgers conference, and one of my former interns is coming in. She was a student and intern at the store, and she is going to relieve me. One of my former interns works in a high-volume operation. We have asked him, "How does it work? What chance do you have to meet the public? Can you perform all the things that we taught you and insisted upon when you worked for us?" He said, "No." He is under such tremendous pressure to turn out, he does not get to meet the public. There is a clerk who receives the prescription from the patient, and, if the clerk has enough knowledge, she will ask the patient if there are any allergies and if there are any idiosyncrasies in the family. Then she will hand the prescription to the pharmacist, and he will tell her how long it will take. He told us of one incident where, at about 9:00 in the evening, a woman handed him an antibotic prescription for a child---

ASSEMBLYMAN BAER: Excuse me, sir. You are giving me more examples, and I was really trying to get to the thrust of what you were trying to say. When you give these examples of contrasting treatment, I don't know if you are trying to suggest that certain types of operations should be put out of business. If they are not operating properly, it would seem to me that it is not a question of advertising. I don't see how advertising would be the key to that. If they are not operating properly, perhaps we have to address the question of standards so that a certain level of performance is required, and the extra effort will be given when circumstances warrant it. Perhaps there need to be

standards to define that type of thing. But I don't see how that relates directly to the subject matter of the bills.

MR. BRAVERMAN: I agree with what you are saying in regard to the level of standards being raised. Advertising is not going to raise the level of care of the health and welfare of the citizens of New Jersey when the professional knowledge is completely lost to the patient. I would hope that, as a profession, we could do it by ourselves through our own efforts. But, if it cannot be done, then I am forced to agree that it may be necessary for regulations to be introduced that will enforce it.

ASSEMBLYMAN BAER: Enforce higher standards?

MR. BRAVERMAN: Yes.

ASSEMBLYMAN BAER: In terms of higher standards, could you supply us with material that would suggest the content of such standards? I realize that your testimony today has been primarily to portray contrasting situations insofar as treatment is concerned. To go into a detailed discussion on the specifics of the standards themselves might take up a great deal of time. I am sure that you also realize that it is not an easy task to develop standards that will help solve the problems. If you can provide us with that information, it would be most welcome.

MR. BRAVERMAN: I have made a notation to contact our attorney, and we will submit to you the same material that we submitted to the New Jersey Health Services Plan for the Medicaid Waiver Project that is to be introduced into Newark.

ASSEMBLYMAN BAER: Let me ask you a couple of questions in another area, because I am fascinated by your explorations into a centralized system relating to patient profiles. I think you heard my comments about

that earlier.

MR. BRAVERMAN: Unfortunately, I did not; I was at work this morning.

ASSEMBLYMAN BAER: It seems to me that, if the system does have value - and there have been some very forceful statements and examples given as to its value - it is important that it be expanded to c o v e r most of the medication that patients purchase. Since patients, or clients, purchase from many different sources, the effectiveness of the system is limited. That effectiveness can only be diminished or improved to a marginal degree based on the impact of having advertising or not having advertising and the effect of that on the dispersal of buying patterns. With a centralized system, such as you have been exploring, the system would, of course, be many times more effective than at present. My first question concerns the economics of it and whether your work up to this point has indicated that such a centralized system can be handled economically or anywhere near the cost of the present system.

MR. BRAVERMAN: At the present moment, with the present technology that exists, it cannot be done. However, Scientific American magazine of this month has a picture of a microcomputer on the cover. It's 2 x 2¼ inches.

ASSEMBLYMAN BAER: I subscribe to it.

MR. BRAVERMAN: Then you saw the cover. I don't know whether or not you read the article.

ASSEMBLYMAN BAER: I read it.

MR. BRAVERMAN: I agree with the man. We don't know what is going to come out of it, and the odds are that it is about five years hence. At present, as he said in the article, t h e Bell System is using it for First National City Bank in New York for the

Citicard program. But, up to this time, we have been examining this whole thing only in relation to a closed system, the Newark Medicaid Waiver Project. The other program that does exist was on Dan Rather's CBS program covering the drug interaction story. He went out to San Joaquin, Stockton, California, and he spoke to Dr. Talley, who is the head of the program, the San Joaquin Foundation for Medical Care. Their system is strictly after the fact. If you saw that program, you saw that they had a peer review committee at work, but they were examining the situation after it had taken place. We are trying, in conjunction with this organization in Hackensack, to devise a system that might be viable at this point. The difficulty is in getting the money. We think we are going to have to go to the federal government to come up with a $2 million or $3 million grant for the hardware in order to introduce the program. We have a problem. The federal government says that it is going to give matching grants to New Jersey. As Commissioner Klein stated at the Board of Trustees meeting of Newark Medicaid Waiver, we have a budget crunch in New Jersey, and we are not sure that the Newark Medicaid Waiver Project is going to be able to take off. So we're not sure how we are going to be able to proceed with HEW.

ASSEMBLYMAN BAER: I have one last question on this. I would, of course, appreciate receiving any further information you can send me on this.

MR. BRAVERMAN: On the computerized system?

ASSEMBLYMAN BAER: Yes. I assume that there must also be companies exploring the commercial possibilities of this. Is the main cost limitation based on the hardware, or is there an inevitability of it costing more because of the cost of the communications system to tie it together? If this were tied together, for

instance, on Bell lines used by every pharmacist to tie into a central computer, would the cost of that communications system be such that it would represent a problem even if the hardware were very inexpensive?

MR. BRAVERMAN: Let me explain something further about this computer system. We are trying to interest the federal government in it; therefore, we are not just going to have a computer hardware terminal, CRT, in every pharmacy participating in the program. There will also be one in every participating physician's office, and every hospital emergency room will have one. The idea of that is this: If, at 3:00 in the morning, somebody shows up at an emergency room without a medical history, and if that person is unconscious, it can be determined if he has a medical problem. I have had that situation with one of my patients. Fortunately, the man was wearing a bracelet that said, "I am a diabetic." The intern who received him in the emergency room thought, "I have an alcoholic on my hands," because the man was unconscious. This is why we are trying to make as complete a system as possible. In addition, the federal government says that Newark is a demonstration project, and they need facts and figures at the end of it. So we are trying to encompass all of it in the program.

We also have another problem: the legal aspects of the situation. Here we are thinking, "How are we going to proceed?" Number one, in no case will we use a person's social security number, because too much information is now in computer memory banks under social security numbers. There is already a lot of talk about a baby getting a social security number before he gets a name. Therefore, we are trying to figure out some way of getting the information into the computer while at the same time protecting an

individual's right of privacy.

Part of the problem is that, when a doctor sees a patient, how is he to know if the prescription he wrote was ever filled? We are trying to incorporate all this into one system so that he will know if the prescription was filled and if the patient responded to the medication. Then the government can push a separate series of buttons to receive all the statistics: demographic, mobidity, mortality, etc. But they will get this without identification of the individuals. If the City of Newark wants to have an ongoing study - the Newark Department of Health is supposed to be overseeing it - wants to get statistics, wants to know if the patients in the area are being treated, and wants to know what they are finding in the area, they will be able to go in without locating individuals and without locating the doctors who are seeing them.

But, at this moment, the only thing I can do is make this profile card as complete as possible. That is the reason I have this one card in red. I call these "problem patients." They are Indians, and I think they have difficulty in understanding the language. I think perhaps I speak too fast for them to understand what I am driving at.

ASSEMBLYMAN BAER: Thank you, Mr. Braverman. Before you leave today, would you have a copy made of this patient profile card for the committee's reference? Are there any other questions? Mr. Rys.

ASSEMBLYMAN RYS: If you had this centralized computer system, what would you do with John Doe's prescriptions, and how would it help people coming into your city from Virginia, California, etc.?

MR. BRAVERMAN: Because the computerized program would be limited, we would have to go through the process

we use at the present time for those coming in. We complete a record by asking: Who is the prescription for? What is that person's age? Are you visiting someone here? Are you aware of any medical problems? We are watching with interest the Canadian government which has started a program in Saskatchewan and hopes to put it into a nationwide system. We may find our answer in Canada.

ASSEMBLYMAN RYS: I think they're talking about fingerprinting, aren't they?

MR. BRAVERMAN: No, computer programming across the whole country, but they are starting in one province.

ASSEMBLYMAN RYS: But they are talking about names, and most likely they will bring in fingerprints. We'd have a problem with that.

MR. BRAVERMAN: That would be a problem.

ASSEMBLYMAN RYS: That's what I'm trying to bring out.

MR. BRAVERMAN: We may go to voiceprints.

ASSEMBLYMAN RUANE: What's wrong with using social security numbers?

MR. BRAVERMAN: There are too many records on file already under individuals' social security numbers. For example, let's say that an individual caught gonorrhea and was treated for it. Should this be a part of his other records? Should it be a part of his work record? Should it be a part of his voting record? We think this should be an extraneous matter.

ASSEMBLYMAN RYS: In other words, you don't want his medical history to be available to anyone else.

MR. BRAVERMAN: Right.

ASSEMBLYMAN BAER: Are there any other questions?

(No questions.)

I want to thank you for your testimony, Mr. Braverman.

It was extremely interesting and valuable. We would appreciate receiving any supplemental materials you may wish to submit.

MR. BRAVERMAN: I attended a two-day seminar in Boston sponsored by the Association of Law and Medicine. I met one of the men from San Joaquin, Dr. Tally's assistant. The interesting thing was that, when they found out that I was a pharmacist from New Jersey, they wanted to speak to me about our profile cards, because we are the only State in the Union that has this system. Dr. Harrington, from San Joaquin, wanted to know what we had, because their system is after the fact.

ASSEMBLYMAN BAER: Thank you again.

Dr. Bernard Miskiv.

B E R N A R D M I S K I V: Good afternoon, Mr. Chairman and distinguished members of the Assembly Committee on Commerce, Industry and Professions. My name is Dr. Bernard Miskiv and I am currently an active New Jersey licensed optometrist who is in private practice in Cherry Hill.

Just to depart from my prepared remarks for a short statement, I have been present through just about all of this hearing the past two days. It seems with every argument, pro and con, I have heard the statement how things may be - how things might turn out - what may or may not happen regarding both the pharmacy and optometry bills. The information I am going to present is how things are currently taking place in the State of New Jersey, how the optometry laws are being covertly circumvented, how the statutes are being broken and, as of the present time, are not being enforced.

Reading from my statement, from approximately August to December 1973, I practiced optometry in

a "covert" commercial environment at two locations: Eatontown and Trenton, New Jersey.

While in Eatontown, I worked for an optometrist who leased space from a large commercial chain optical company. The managing optician offered me a position in one of his stores in the Trenton area -- largely because of the very fine job I was doing for them in Eatontown -- as he put it to me. While in Trenton, I was in a lessor-leasee arrangement that extended well beyond what many in this room would consider such an arrangement to be. In fact, as time went on, I was made to feel that I was owned by the optician next door. In actuality - he was really my godfather.

My lease, which was very similar to the one Dr. Appel has, stated that I was merely renting space and equipment for the sum of $200 a month to practice my profession. When in actuality, I owed my very livelihood to the lay person next door. I ask each and every member of this Committee, especially the attorneys here present, how can you strive to help the public and protect the consumer, when every professional act you perform has a lay person looking over your shoulder trying to see how he can turn it into a quick-money-making proposition? Is this a mere tenant-landlord arrangement?

The very nature of the provision in the current law that Assembly Bill 3263 will delete is presently being violated and circumvented. I know - I was there. To wit:

1. Hours: The lease stated that I had to be there all hours the store was opened.

2. Flow of patients: They were sent from next door and could be cut off at any time. In my particular case, they were.

3. Fees: I was told not to charge more than $12 for an examination. When I defied this and raised my

fees to $20, my lease was cancelled by the optician. The reason I was given was that in their opinion I was not now practicing optometry the way they, the chain optician, thought it should be practiced.

4. Prescriptions: While working in Eatontown, I was instructed to prescribe optical appliances to every patient whether needed or not. When I complained about this, I was told that "the optician wanted every patient to receive an Rx." Subsequently, I found out that the reason for this was that the dispensing optician received a bonus for the sale of two pairs of glasses in lieu of bifocals, sun-glasses, tints and other optical appliances. This practice was so flagrant that even my prescriptions were changed by the optician to conform to the power of lenses that were in stock. As an example, my Rx - and I should note without any communication by any person contacting me to see if there was any way it could be changed and my okay - would either be increased or decreased slightly, or even greatly, in order to fabricate the glasses within one hour, as advertised. If the patient returned to me for verification of prescription, I was instructed to ignore accepted tolerances of lens specification.

Gentlemen, this is what is happening today, by the covert circumvention of our current laws. Can you visualize the effect on the visual welfare of our citizens if you legalize this fraud? To allow corporate interests to legally establish these "patient mills" and render eye care which is judged by profit margins instead of professional judgments would be travesty. The decision is in your hands, but the consequence of your decision will affect the visual welfare of over seven million residents of New Jersey.

For these reasons, I cannot see how this Committee

or any State agency with the interest of the consumer in mind could support such destructive legislation. The defeat of A-3263 is essential.

That ends my prepared statement. If I could, I would like to introduce one other very important piece of information. It is quite short. I am not going to read all this. It is just two pages. This has just recently been made available to me.

I think you have heard that there are chain houses, chain operations. This is, I believe, part of a national intent, to change various laws in the states. To help support my argument and to possibly make the point more clear, I would like to read this testimony which was presented on behalf of Dr. Mark Robin, an optometrist, in California, in regard to a law suit - it was in the United States District Court, Central District of California - when he was in a similar situation. He was an optometrist who went out and leased space, and this was his testimony:

"I, Mark Robin, O.D., depose and say ---" (this was made under oath) I will start all over again.

"I, Mark Robin, O.D., depose and say:

"1. I am an optometrist licensed to practice optometry in the State of California by the Board of Optometry.

"2. Commencing on or about July 5, 1974, I leased a fully equipped optometry office adjacent to the dispensing optician office of plaintiff Opti-Cal at 602 and 602A South Broadway in Los Angeles. I paid a token rent for the premises and equipment and was subsidized by Opti-Cal to give eye examinations in my office. My guaranteed income was $2500 per month, and each month Opti-Cal paid me the difference between the money I received from patients for eye examinations and the $2500. I was prohibited from dispensing eyeglasses or contact lenses. Most of my patients were referred to me by Opti-Cal's office next door.

"3. Shortly after Opti-Cal began advertising the price of eyeglasses, I began receiving an inordinate number of complaints from patients who had had their prescriptions filled by Opti-Cal next door. In each and every case the lenses furnished by Opti-Cal either grossly deviated from what I had prescribed, or were aberrant and of poor quality, or were fabricated in such a way that they did not conform to the patient's facial measurements. When I inquired of Opti-Cal's optician, George Sandman, about this situation he told me that too many glasses were being returned to their laboratory as defective merchandise and that to alleviate this problem the home office had sent a written directive to all Opti-Cal office managers; that the directive had ordered that henceforth all glasses, when received from the lab, were to remain in their sealed envelopes. The seals were to be broken only in the presence of the patient and dispensed without verification. The glasses were to be checked for accuracy only if the customer later complained about the glasses.

"4. During this period I insisted on verifying all contact lenses which Opti-Cal dispensed pursuant to my prescriptions. The general rule was that the power in Opti-Cal's contact lenses were off beyond tolerance, the optics were distorted, and fitting curves had been poorly applied. I also observed lenses whose edges were either partially or totally unfinished. The edges were squared off and unpolished instead of being rounded and smoothly polished. On a number of occasions, the edges were jagged and serrated with no edge treatment in evidence. This would do serious damage to the eye.

"5. The day before Opti-Cal commenced price advertising, Mr. Daniel Adair, an official of Opti-Cal, told me in my office that the only way to realize a profit at the advertised price was through high volume;

and that the only way to insure this volume is through price advertising. He stated that every facet of their operation was geared to high volume and low overhead.

"6. Opti-Cal lowered its prices substantially when it began advertising its prices. Opti-Cal's price advertising of eyeglasses contributed to and directly caused the deterioration of quality and workmanship as described in paragraphs 3 and 4 above.

"7. I am not being paid by anyone to make this affidavit and have no connection with any optical companies.

"Dated: 4-30-75 -- Mark Robin, O.D."

This was a duly-sworn statement.

ASSEMBLYMAN RYS: Who was the doctor?

DR. MISKIV: Mark Robin. As I stated earlier, he is a licensed California optometrist who was in a similar side-by-side operation in California. He presented his testimony before the Attorney General.

ASSEMBLYMAN BAER: Will you leave a copy of those pertinent pages for inclusion in the record? I take it you are not requesting that the whole document be put in the record.

DR. MISKIV: Do you want the whole document?

ASSEMBLYMAN BAER: No. I take it you are not requesting the whole document be put in the record.

DR. MISKIV: Right.

ASSEMBLYMAN BAER: If you could separate those pages ---

DR. MISKIV: I will have copies made.

ASSEMBLYMAN RYS: Dr. Miskiv, that deposition was made in California and was very interesting. However, I am even more concerned with what is happening in the State of New Jersey.

On the first page of your statement, you admit that you practiced optometry in a "covert" commercial environment at two locations, Eatontown and Trenton. Can we have the names of those two concerns?

DR. MISKIV: Dr. Appel who testified this morning -- I worked with Dr. Appel. I was employed by Dr. Appel.

ASSEMBLYMAN RYS: I don't recall his giving any testimony pertaining to any "covert" establishments in the State of New Jersey, but you have. You have pin-pointed two locations.

DR. MISKIV: Would you like me to clarify that point?

ASSEMBLYMAN BAER: Would you do that.

DR. MISKIV: The first place I mentioned was Eatontown. In Eatontown, Dr. Appel has an office adjacent to Hillman-Kohan. He leases space from Hillman-Kohan. I was employed by Dr. Appel on a part-time basis three days a week, at which time I examined patients for prescriptions.

Subsequently, I was offered, as the optician put it, my own store, in Trenton, in a similar situation. This time I leased space directly from Hillman-Kohan and I ran a similar operation to Dr. Appel's. They told me I was offered this position because of the fantastic job I was doing for them in Eatontown.

After I was in Trenton for two months, my lease was cancelled, the reason being, in their estimation they did not think I was practicing optometry the way it should be practiced.

ASSEMBLYMAN RYS: I presume this was known to you as soon as you received your employment or a few months after that. At any time, did you make known your opposition to this and notify the New Jersey Board of Examiners pertaining to this?

DR. MISKIV: Can I say that testimony along these lines, my complete testimony in connection with questioning by the Attorney General's Office, is in the hands of the State Attorney General. I think your Committee can get copies of all my sworn testimony. There are quite a few hundred pages in the transcript.

ASSEMBLYMAN RYS: Before the Attorney General?

DR. MISKIV: The Attorney General has all the evidence. He has all the names and addresses. The Division of Consumer Affairs, of which Mrs. Annich is head, has been made aware of this fact.

My own personal opinion is that in their estimation there is no covertness occurring. I have been there; I have seen it. The cases to substantiate this, as I say, have been turned over to the State. They are in the hands of the Attorney General.

ASSEMBLYMAN RYS: Had I know this before I questioned you, I wouldn't have pursued that point. However, I want to congratulate you for bringing this to our attention and to the Board's attention. You say it is before the Attorney General at the present time?

DR. MISKIV: Well, no. The Consumer Affairs Division and the Attorney General have concluded their reports. They have all of the evidence pertaining to the circumstances that I reported to them. As far as I know, it is a matter of public record.

ASSEMBLYMAN RYS: Do you have a copy of that?

ASSEMBLYMAN RUANE: What was their conclusion?

MR. YOUNG: There was no conclusion rendered. They have all the evidence. This was sworn testimony that was given by a number of people. I think I should make it clear to the Committee that I think Dr. Miskiv is not hedging questions. There is litigative action involved. At this point, I think it would be well if he did not go beyond that.

ASSEMBLYMAN BAER: Could you identify yourself again, please?

MR. YOUNG: Dennis Young, Executive Director of the New Jersey Optometric Association.

Dr. Miskiv wished to testify, but we made him aware of the fact, since there is litigation involved, there are some areas that cannot be discussed. But if

the Attorney General feels free to transmit information to this Committee, we have no objection.

ASSEMBLYMAN RYS: We will try to get it.

ASSEMBLYMAN BAER: I would like to ask you, following on Mr. Rys' question, this: You indicated that there was a conclusion by the Attorney General and, if there has been one, can you get that to us? I am a little confused because there seems to be a contradiction in what has been said here as to whether there was or wasn't a conclusion by the Attorney General. Can you clarify that?

MR. YOUNG: If I might, I think I might be helpful because I don't know whether Dr. Miskiv is aware of this. The Attorney General has received all of the information. The information still must go to the New Jersey State Board of Optometrists because the Attorney General has no judicial power. The Board must exercise that power. The Board has not rendered a decision.

ASSEMBLYMAN BAER: That doesn't rule out the fact he may have prepared some conclusions, regardless of the limitations on what action he can take, and I would like to know if there have been some conclusions, as you indicated, how we can get hold of them.

DR. MISKIV: Okay. I will just say this: In my opinion as an actively licensed practicing optometrist in the State of New Jersey -- it is my opinion, not as a lawyer, but as an optometrist, that the statutes of the State are being violated. They have been violated. I have tried to make people aware of this point. As far as I know, it is still in the process of being decided.

Okay? Are you asking me do I think the law is being broken in my opinion?

ASSEMBLYMAN BAER: As I understood your statement, it was that the Attorney General had reached the conclusion or prepared some conclusions that in his opinion there were not violations. What I am asking about is the availability of those conclusions and whether that

is what you meant to say, that the Attorney General has prepared some conclusions, because I am very interested in this Committee getting those conclusions of the Attorney General. Whether or not they have any final effect in adjudicating this case, I would like to know what conclusions he has prepared, if he has prepared conclusions as you seem to have testified to. Can you identify when these were prepared and give us any information about them so we will be able to get hold of them?

DR. MISKIV: Let me put it to you this way: If that is the impression I left, it was the wrong impression. If he has made any conclusions, I certainly am not fully aware of them. I do not have any copies of them. If I did, I would probably be more than happy to supply each and every member of this Committee with copies.

I think that the final jurisdiction of the matter will probably be with the State Board, as Mr. Young has stated. From there, I am sure it will become public.

ASSEMBLYMAN BAER: Thank you.

Mr. Ruane.

ASSEMBLYMAN RUANE: I would like to make the observation that all these bills plus some others that this Committee has investigated, such as the drug bills, seem to point in one direction. that there is complete lack of integrity in the entire medical field. This is the direction it seems to point, because of the fact that medical costs in optometry and drug costs are soaring at such a rate that the average citizen can no longer afford to get sick or have an eye defect.

What are your thoughts, if you have any, on how we could limit these astronomical charges by some doctors while the charges of other doctors are within the scope of reality, without having advertising? I mean, in what other ways could we accomplish that? You refuse to regulate yourselves. So, obviously, there is a void and the Legislature must fill it somehow.

DR. MISKIV: Assemblyman, if I may, I would like to answer your second question first.

In the first place, I do not think we refuse to regulate ourselves. I think, as was stated earlier in this testimony, that New Jersey has a model optometry law. I think it really comes down to this: Is this hurting the public or is it not hurting the public?

ASSEMBLYMAN RUANE: That is the reason for the question. What do you think?

DR. MISKIV: In my estimation, this type of operation is hurting the public. I think, however, if the laws were enforced the way they are on the books now, this situation would not be in existence.

To answer the first part of your question, I do not think that the cost of professional, good-quality eye care is out of sight of anyone's reach really.

ASSEMBLYMAN RUANE: Let me ask you this: How long does it take you to do an examination?

DR. MISKIV: It varies. I will tell you what happens in my office currently. It takes me anywhere from one half hour to forty-five minutes. I think this is where the crux of the matter is, not in the length of time: When I was with Dr. Appel, I did not violate the law; I performed a 16-point examination and I saw x amount of patients a day. But the whole problem was that the procedures that were performed didn't mean anything. An example: The law says you must perform a visual fields test or a perimetry to see if a patient has adequate peripheral vision. If it is done the way it is supposed to be done it could take anywhere from five minutes to ten minutes. But in order to get a fair estimation of peripheral vision difficulty, you could probably perform the test in about a minute.

At the office, you couldn't spend that much time. You had to go through a complete exam in about ten minutes.

Consequently what was done and what is being done is that you cover a patient's left eye, for instance, and you take the wand and you go like this (indicating) and you go to the other eye and you go like that (indicating). That is the extent. So all you are doing is the mechanics. When you end the 16 points and get down to the end, you have no time to evaluate what the patient's complaints are; you don't have any time to evaluate what your findings are. You don't even care what your findings are. All you want to make sure is that all the little things are filled in so when the State inspector comes around, there are numbers there, which, by the way, the State inspector doesn't know.

ASSEMBLYMAN RUANE: In your testimony you said you were told not to charge more than $12, but you defied this and raised your fees to $20. Now you just mentioned a 10-minute examination by pressure from them.

DR.MISKIV: That's right.

ASSEMBLYMAN RUANE: Multiply that and see how much you would be making an hour, Doctor. We have been talking about the astronomical price.

DR. MISKIV: You are talking about volume.

ASSEMBLYMAN RUANE: Regardless of that, you are talking about $20 for a ten-minute examination.

DR. MISKIV: No, no. Maybe I should clarify what the price was. Dr. Appel's fees were $12.

ASSEMBLYMAN RUANE: And he was sending you patients in such volume that you could only spend ten minutes with each patient. Isn't that what you just said?

I am not against you as a professional making a fair and equitable profit. But while we are here considering these various bills, I thought I might mention the fact that there is a great disparity between what a lay person earns and what the medical profession, per se, is making. And I wonder whether the education involved in their

training justifies an astronomical charge which may bring us to socialized medicine in this country which nobody wants. Well, some people want it, but the vast majority would rather have their own personal physician and their own optometrist, etc. What you are saying is ambiguous, to say the least. I won't pursue it further.

DR. MISKIV: If I could have a second to try to answer it, I would appreciate it. I mentioned about the fees not from the standpoint of how much the doctor would be making. Of course, as I say, you have to realize that the reason for having an optometrist there is for one purpose and one purpose only, to feed the monster next door. There is a monster next door that survives not from the optometrist being there but from the amount of prescriptions turned out. And how to get the prescriptions turned out fast and get the patients to come in is to advertise or get the word around that you can have a so-called complete, competent eye exam done for below the accepted fee. Okay?

The reason that I put this in the testimony here was not to bring out the fact that ---

ASSEMBLYMAN RUANE: --- you were making a million dollars?

DR. MISKIV: I wasn't making a million dollars. In fact, I will even tell you that Dr. Appel was paying me $250 a week.

The reason that I brought this out was to show the control of the professional judgment. If it is true it is a landlord type of relationship and you are renting something, why would the landlord be concerned about what you charge for your professional services? I don't know whether you are an attorney.

ASSEMBLYMAN RUANE: I am not.

DR. MISKIV: I mention this because I thought most members of the Committee were attorneys.

ASSEMBLYMAN RUANE: That is a presumption.

ASSEMBLYMAN BAER: It is a common misconception.

DR. MISKIV: I just brought that up because I thought it might strike home.

ASSEMBLYMAN RUANE: My point is that what is coming across to the average layman is that the professionals have a right to steal by virtue of their education. That is the point I am trying to bring across. It is erroneous, but it is there.

DR. MISKIV: I hope that is not the way you take the point that I am trying to make.

I am trying to make the point that if they control how many patients you are to see, what your fees are going to be, how you are to prescribe and change your prescriptions --- A patient comes back for verification on BRX. You are told to totally disregard accepted lens tolerances. As you can see from testimony given by an optometrist in a similar type of situation in California, this is the gist of it. It gets down to the point where a patient comes in and he is complaining of headaches, maybe his bifocal has to be stronger or maybe he has glocoma. How are you going to be able to evaluate this patient by the use of drops and so forth, to do a pressure test, to see when he gets this and get into the whole picture, if you are being forced -- You know the person next door doesn't give a darn about this. He wants that Rx to fill that prescription. So the volume goes up, but the quality does down. It has to.

Another good point is just the fatigue you suffer. There is a certain amount of mental fatigue, etc., repeating a test over and over again. Anybody, I think, in the course of time will get a little sloppy and the competency of the exam and how it is performed starts to get eroded. This is happening now. I think this is the reason I wanted to come before this Committee. This is not a

case of my coming and telling the Chairman and the distinguished members of the Committee that this may happen and that, if we change the law, this may happen, a Chicken-Licken thing - the sky is falling. This is going on right now. You can find this out today on your way home if you want to stop off and see it.

ASSEMBLYMAN RUANE: Your basic conclusion then is that with high volume, you lose quality.

DR. MISKIV: That is one of them.

ASSEMBLYMAN RUANE: Thank you.

ASSEMBLYMAN RYS: Dr. Miskiv, we are happy to have you here as a witness. How many examinations were you making per hour?

DR. MISKIV: Per hour, where?

ASSEMBLYMAN RYS: Where you were working. You say you charged $12 for the examination.

DR. MISKIV: No, I didn't charge $12. That was Dr. Appel's fee. When I was subsequently offered a store in Trenton, I had a meeting with the chain operation and they told me there were certain restrictions placed in the lease. There was a 30-day cancellation clause.

ASSEMBLYMAN RYS: What I am trying to do is clarify the ten minutes that you spoke about before.

DR. MISKIV: The ten minutes is what the exam got constricted to.

ASSEMBLYMAN RUANE: And you charged a fee of $20.

DR. MISKIV: No.

ASSEMBLYMAN RYS: That is what I am trying to bring out.

ASSEMBLYMAN RUANE: Let him retract his statement then.

ASSEMBLYMAN RYS: As Assemblyman Ruane is saying, I think you are off tangent on that. I think you ought to correct your statement. Just compose yourself for a minute and give it to us again.

DR. MISKIV: Do you want me to start again?

ASSEMBLYMAN RYS: Yes. In other words, Assemblyman Ruane is of the opinion - and I also got the opinion - after figuring this out that you must be making close to $900 a day or week but you say you were making $250. So try to clarify that.

DR. MISKIV: I brought this out from the standpoint of control. At the Eatontown operation, I was not charging. Dr. Appel had two women working there. The fee was $10 if you were under 40 - I think that was the age - and over 40, the fee was $12, the $2 extra being for pressure checking. This is the way the fees were broken down.

When they offered me a position in the Trenton location, I was instructed my fee would be $12. At the Trenton location - it was a new location - the volume was not what the volume was at the Eatontown store. Consequently I had more leeway. I was doing a complete examination again. This time I was able to take the time to evaluate the basis of my findings. Consequently, my exam was lasting --- I hate to put it in terms of minutes because you could have a patient and run into a problem and go an hour and a half with him. The Committee seems to talk about averages. Let's say the average was a half hour to forty-five minutes. This was what my exams were running in the Trenton store.

ASSEMBLYMAN RUANE: We will take your word for it because the other way you were making $960 a day, without a gun.

DR. MISKIV: Assemblyman, I think you have the wrong impression.

ASSEMBLYMAN RUANE: I was taking you at your word though.

DR. MISKIV: I can see how it could be taken both ways.

ASSEMBLYMAN RUANE: Let me ask you a further question then. What is the average yearly income of an optometrist in the State of New Jersey?

MR. YOUNG: According to a survey done about a year and a half ago, approximately $22,000 a year.

ASSEMBLYMAN RUANE: Thank you.

DR. MISKIV: This is new and old optometrists all together.

ASSEMBLYMAN RUANE: I just wanted to know the average for the profession.

MR. YOUNG: I would like to ask the permission of the Committee to respond because I think you are taking the analysis out of context. It is unfortunate this is being recorded in the record because the assumption that is being drawn is totally on the other side of what Dr. Miskiv was trying to say.

ASSEMBLYMAN BAER: If we have time at the end and you want to testify further, we can hear you. But I would rather continue with the order of witnesses. If we get into a procedure where everybody here can break in at any point where they feel they would like to add to the testimony, we would have no order whatsoever. I am sure you can appreciate that.

Proceed, please.

ASSEMBLYMAN RUANE: I have no further questions.

ASSEMBLYPERSON CURRAN: Is the Dr. Appel you are talking about the same gentleman who was here this morning?

DR. MISKIV: Yes, Dr. Richard Appel.

ASSEMBLYPERSON CURRAN: To get back to the problem this morning, he was the non-dispensing optometrist who was connected with this operation.

DR. MISKIV: If I could, I would like clarified what you mean by "connected." He contends that he is separate and distinct. His address was given this morning as Route 35 and Wall Street, Eatontown, which is the same address as Hillman-Kohan. They are one and the same.

ASSEMBLYPERSON CURRAN: Would you say in your opinion - and I think I am putting you on the spot, but

I don't mean to - that my question to him about any connection in regard to - well, he used the term "kickback" - I did not, but I used something much more general and much less legal, if you will - was a nontruthful response?

DR. MISKIV: In my opinion?

ASSEMBLYPERSON CURRAN: Yes, in your opinion. And I realize I am putting you on the spot and it is unofficial.

DR. MISKIV: Yes. I was there and I saw it. You know, I think this is something you have to see to believe. But you realize it when you go in there and see that the heating control and the lighting controls are not in his office, but next door. When the store closes, he is out of business; his power goes off; his heat goes off; his electricity goes off. When patients come in, they say, "Are you connected with next door?" Patients are really the ones who seem to realize that they are one and the same operation.

ASSEMBLYPERSON CURRAN: Getting to the matter of these leases, actually your lease was cancelled -- I want to get it straight -- it wasn't really cancelled but it was never in effect. Is that it?

DR. MISKIV: No, I had a signed lease.

ASSEMBLYPERSON CURRAN: You signed a lease, but you never really started working?

DR. MISKIV: No. When I was working with Dr. Appel --- You see, one optometrist can employ another optometrist.

ASSEMBLYPERSON CURRAN: So you had a contract with him as an employee?

DR. MISKIV: No, I didn't have a contract with him; he just paid me a salary. After I was there, I think, about a month and a half or almost two months, the head optician called me up and he said that they were moving optometrists around and they had an opening for me in a store location in Trenton. He said because of the great job I am doing for them, would I be willing to take it.

In other words, he wanted to give me a similar operation and he offered me a lease. They had me up to their offices. I looked it over and signed it. There were certain restrictions in the lease. A few of the more important ones I brought forth to this Committee.

ASSEMBLYPERSON CURRAN: Could I stop you right there. The lease said you may not charge more than $12? This just doesn't strike me right as being part of a lease. It strikes me as being part of a contract for work.

DR. MISKIV: I gave sworn testimony on all these particulars and everything. The data that has been collected during this is in the hands of the State Attorney General and the Division of Consumer Affairs. I really think you could get better chronological data by looking through all the different dates and seeing the whole progression instead of picking out and asking what was on such and such a page of this lease at such and such a time. I think if you were to look through the evidence that was presented to the Attorney General by myself and other witnesses, of course, you could see this whole story unfold.

I might say my lease was cancelled for this and for no other reason from what they tell me - that they didn't think I was practicing optometry the way it should be practiced in a chain location. Yet they offered me a location of my own because they told me I was doing such a great job. So there had to be other reasons for this.

ASSEMBLYPERSON CURRAN: I am very grateful that you have come to talk to us today and I don't mean to question your motives. I am just trying to get at the whole spectrum here. Dr. Appel and a couple of other people mentioned earlier that one of the reasons that young optometrists get involved in this kind of thing is because it is difficult and expensive to go out on their own, and I can appreciate that. But if you knew what kinds of things were going on basically in Eatontown, why would you

take a chance on getting involved in that kind of thing in Trenton?

DR. MISKIV: Do you mean, why did I sign the lease? You are asking me why I signed a separate lease with them?

ASSEMBLYPERSON CURRAN: No. I am asking you ethically if you were told in Eatontown when you were simply an employee that you had to give a prescription whether or not people needed it - every person gets a prescription and that is it - why would you get involved with those kinds of people to continue your professional career? Are things that bad that you are forced to that?

DR. MISKIV: I think you have to remember I didn't sign a lease with them in Eatontown; I worked with Dr. Appel. If I refused to do it, I would simply have been fired. When I signed my own lease, I was in effect in a similar type situation as Dr. Appel had in Eatontown, and,consequently, patients came into my office adjacent to Hillman-Kohan in Trenton and, if I didn't think they needed a change in prescription, etc., I wouldn't give it to them.

You have to remember that again I am getting back to stuff that is in testimony that is in the hands of the Consumer Affairs Division. I think you really have to go back and see how I became involved in it after I came out of the service. This has been going on for quite a few years now.

ASSEMBLYPERSON CURRAN: One quick question: Did anybody ever check prescriptions from the State's viewpoint? Was there any enforcement attempted at all? Did anybody ever come in ---

DR. MISKIV: As far as I know?

ASSEMBLYPERSON CURRAN: Yes.

DR. MISKIV: Do you mean when I was either in the place at Trenton or in Eatontown?

ASSEMBLYPERSON CURRAN: You heard the earlier testimony that we really don't have enough Inspectors or any qualified Inspectors at all. Did you ever see anybody check anything from the State?

DR. MISKIV: One time I was there and a man came in in a black suit or some type of suit and flashed a credential that said,"Division of Consumer Affairs." He looked at something and walked out. That's all. As far as checking spectacles, no. Patients did come back to me for verification of spectacles which I found to be wrong. When I questioned it, of course, a lot of steam broke loose.

If I could, there are just a few salient points -- I was present this morning when Dr. Appel testified ---

ASSEMBLYMAN BAER: Are you finished with your questions?

DR. MISKIV: I'm sorry.

ASSEMBLYMAN BAER: I would like to ask a couple of questions very briefly because I know we have three witnesses waiting.

In relation to the lease here, first of all, we would appreciate it if you could provide us with a copy, if you have it, of that lease.

Secondly, I would like to ask your opinion as to whether you think legislation is necessary, restricting such leases, either in terms of their content or prohibiting such operations from leasing space or in other ways being able to control the operations of optometrists. This lease, for instance, was the vehicle for exerting pressure for unprofessional conduct, as you say, or performance not up to standard. To the best of your knowledge are existing statutes from your discussions with the Attorney General, etc. - you have spent time on this - adequate to cover that, if enforced; or do we need further statutes in this area of leasing?

DR. MISKIV: Again, Mr. Baer, as I have said, the lease and pertinent documents and sworn testimony have been given by me before the Attorney General.

ASSEMBLYMAN BAER: I am not asking you about the criminal matter and I am not asking you what your testimony is so far as the guilt or innocence of any of the people involved. I am asking your testimony in relation to our legislative function and I am interested in exploring whether it would be desirable for us to pass legislation that would limit the ability of such opticians to provide leases for optometry operations, or to outlaw them altogether, or to limit the clauses or bases on which such leases can be cancelled or not renewed, so as to prevent any such pressures on a general basis.

I am not asking you about the specific evidence in this case and I think you ought to have no restraint in giving us your frank opinion on that.

DR. MISKIV: All right. You would like my personal opinion?

ASSEMBLYMAN BAER: Yes.

DR. MISKIV: First of all, I could supply you with the lease, number one.

Number two, my opinion is that I don't think the current statutes are being enforced. They are being circumvented. I think as members of the Committee here if you wanted to pass any law, in my opinion, it has been proven over and over again, no matter which law you pass, you can always find a loophole in it someplace.

You could say there is no advertising allowed on TV and maybe five years from now, they won't have TV anymore. They will have some type of sophisticated transportation and you could advertise over that. So you have found a loophole in the law.

I think the current law would take care of the matter if it was enforced. This again is my personal opinion. This is another reason why I wanted to come

before the Committee.

ASSEMBLYMAN BAER: Which law is that?

DR. MISKIV: The optometry law - the statutes on the books of the State of New Jersey.

ASSEMBLYMAN BAER: Very good. I have no further questions. Thank you very much.

DR. MISKIV: Could I just enter a couple more short remarks?

ASSEMBLYMAN BAER: Make it very brief.

DR. MISKIV: This morning, I understand Assemblywoman Curran asked a question -- Dr. Appel was talking about dispensing versus nondispensing optometrists. He stated he represents about 25 of these optometrists adjacent to Hillman-Kohan. He said they are nondispensing. In fact, several of them have second offices at which places they do examine and dispense

Number two, along the same line, the idea of an optometrist also dispensing glasses or filling his own prescriptions or however you would like to put it is in the realm of what we consider total optometric care. When I was in Eatontown and worked for Dr. Appel, he had it stamped right on his prescription, "Patient to return for verification of Rx." 99.44 percent of the patients never returned either because they weren't satisfied or they just didn't bother to return. So what happens is that you really lose control. In my office and in all optometrists' offices, when a prescription is returned from the lab, the doctor is responsible for verification of the Rx, at which time it can be rejected and remade before being dispensed to the patient. If I write a prescription for a pair of glasses, it is fine if a patient wants to take it out of the office. They are always instructed to come back. But what do you do if they don't come back? There are patients walking around with improper Rx's today and maybe getting headaches. I

even had one patient who was seeing double for two years.

This morning you were trying to get to the economic value. I might point out that improper testimony was given and he isn't just representing, as he stated, non-dispensing optometrists; but at least half of them, I would say, have second offices where they do conduct a total optometric practice.

Just to put everything into perspective, I think the best thing I could get across to this Committee is that you can't draw a line and go up to a point on that line and say, "This is where I think professionalism stops and from here on, this is where it starts." I don't think it is clear-cut. This is in answer to Assemblyman Baer's question: Can you legislate this? I don't think you can legislate it. I think you have to do the best job of optometry that you are taught and that is morally required of you, and this would be adequately taken care of if the present statutes of New Jersey were thoroughly enforced.

ASSEMBLYMAN BAER: You think there should be complete separation between prescribing and providing glasses, including contact lenses?

DR. MISKIV: Well, with contact lenses, there is a little more involved. If you came in to me - I see you are wearing spectacles - and you would like me to fit you with contact lenses, I can't write you a prescription for contact lenses. Nobody unless you are Jesus Christ himself can write you a prescription for contact lenses. I have to sit down and evaluate you and see you back every week for a period of about a month or so. Then I can sit down and write you a prescription.

ASSEMBLYMAN BAER: Thank you very much. We appreciate your testimony and your helpfulness.

Mr. Feldman.

M A R T I N F E L D M A N: Before I start, I would like to respectfully call Assemblyman Ruane's attention to the poster right behind his head. The blue line represents average prescription price on that poster. Every time I hear the expression, "soaring prescription prices," I remember back to our friend, Assemblyman Kaltenbacher, who rode that expression for all it was worth until we had lunch with him one day and we brought him some facts that were ascertained by a New York Times survey. We looked awfully good in that. They really aren't soaring, not like the rest of the economy.

ASSEMBLYMAN RUANE: Let me just go you one for one. The fact you establish a minimum charge for prescriptions is, itself, to be questioned.

MR. FELDMAN: I was just talking about the word "soaring."

ASSEMBLYMAN RUANE: You are talking about one aspect where you look good. But the fact you establish a minimum price can be questioned.

MR. FELDMAN: Sure. Anything can be questioned.

ASSEMBLYMAN RUANE: I am talking about the amount of prescriptions, per se, in any given day.

Go ahead.

MR. FELDMAN: My name is Martin Feldman. I am a New Jersey registered pharmacist since 1951. I have owned and operated an independent community pharmacy in Perth Amboy for over 16 years. My pharmacy is run as what is commonly termed a full-service operation. It is open 7 days a week, 365 days a year. We are open until 12 o'clock at night 6 days a week; on Sundays and holidays, we are open from 1:00 PM until 10:00 PM. We have delivery and pickup service, charge accounts, income tax or insurance statements, compounding of prescriptions, full prescription inventory, a registered pharmacist always available for patient consultation, 24-hour emergency service, and we

have kept family record cards, which you are all aware of now, since 1966 or long before it became mandatory. In addition, all prescriptions are filled by a registered pharmacist or by a pharmacy intern, and checked by a registered pharmacist. We employ 24 full- and/or part-time persons, which includes 5 pharmacists and 2 interns. Our weekly payroll averages about $3,000 net. We dispense between 170 and 185 prescriptions per day. Last year we had a net income on sales of .07 percent.

I have had several years to think about what changes would have to be made in our particular pharmacy if advertising of prescriptions were allowed by law. During this time, I have carefully evaluated pharmacy operations in several large, price-oriented chains, such as Pathmark and Rite-Aid. Let me say right here my information is not from the outside. I have a friend who has been working for Pathmark for the last 7 years, starting as a bench pharmacist and now he is a supervisor and into the policy-making category. He is that high up. So I know their operation inside out. As for Rite-Aid, a gentleman who left Rite-Aid about six months ago took my place in a State job that I also held. He and I had long discussions and there is certainly very little about the Rite-Aid operation as of 6 months ago that I am not aware of. I have also communicated with community pharmacists in Pennsylvania, Florida and Massachusetts where advertising of prescription prices is legal. I should say that is in error. In Massachusetts,it is posting; I don't know about advertising. In Pennsylvania and Florida, they have advertising.

The first thing we would do if this bill were enacted and given a little period of time to see what happens is, of course, reduce prices on easily recognizable, often-prescribed chronic-type medications ---

ASSEMBLYMAN BAER: Excuse me. Could I break in

just a second. Did you prepare this statement? The reason I am asking is that your correction makes me wonder. Did you prepare this statement?

MR. FELDMAN: Certainly - every word.

ASSEMBLYMAN BAER: Okay.

MR. FELDMAN: You mean the correction on Massachusetts?

ASSEMBLYMAN BAER: Yes.

MR. FELDMAN: They have mandatory posting, but I don't know if they have advertising.

ASSEMBLYMAN BAER: All right. Thank you.

MR. FELDMAN: The first thing I would do is reduce prices on easily-recognizable, often-prescribed, chronic-type medications in large quantities. Then I would further reduce the price we charge for birth control tablets, even though the price we charge right now is only 25 cents over cost. We would raise prices on all small quantity, lower-cost, less-frequently prescribed items, which, I might add, is exactly the way Pathmark operates at the moment.

Secondly, we would sooner or later be forced to spend money in various media for price advertising in order not to lose our patients. To compensate for this added expense, we would both reduce and alter our prescription department personnel. We would emulate the chains and have one pharmacist on duty checking the work of three or four non-professional, lower-salaried people. This is perfectly legal, although from a professional viewpoint not preferable, as long as the pharmacist on duty personally places the label on the bottle and checks the prescription. This would also increase the average waiting time from the present 10 or 15 minutes in my pharmacy, to anything from 1 to 2 or 3 hours. We would reduce our inventory by not stocking slow-moving drugs. I heard Mrs. Annich speak about inventories and somebody else yesterday, and I take this opportunity to give you from the book the great discount delusion.

They picked up the slogan that our big discount chains have been using, "Pick on the best, to hell with the rest." They have been using that slogan for years and, using that slogan, they have driven out many smaller hardware stores where you could go in and get a pot cover; the book store, and the grocery store that carried everything. Many of the smaller businesses have gone out because as soon as you take the cream away, you don't have the rest of it- you don't have much left. It is as simple as that. But that is their official slogan, "Pick on the best; to hell with the rest." That is exactly what we would have to do if we wished to stay in business.

WE would discourage patients with compounded prescriptions. Notice I didn't say we would turn them away because they had compounded prescriptions. Our State Board of Pharmacy has determined that the way stores like some of the chains are discouraging compound prescriptions is by simply saying, "We don't have one of the ingredients." When they are asked, "When will you have it in," they reply, "A week from this Tuesday." The customer says, "I need the prescription now. Goodbye." Nobody can call them on that, they just don't have one of the items.

All charge accounts would be switched to credit card charges or there would be no charging. We would continue to offer delivery service and tax statements, but we would charge cost for each. We would also add on a service charge if we had to telephone a physician in order to clarify a prescription or get permission for a renewal.

You heard from Mr. Braverman before how much time you sometimes spend on the phone. I bring that up because we have been informed that one chain in particular that is very large in the State of New Jersey will not allow its pharmacists to call physicians if there is a problem with the prescription because they found that those calls cost a minimum of $2, each, and more, trying to get

the doctor, have him call back, and whatever. So they just hand the prescription back to the patient and say, "I'm sorry; we are out of this."

If these changes were not enough to keep the operation in the black, we would then close on holidays and shorten our weekday hours. Although we are firm advocates of full-service pharmacies, we would not hesitate to change if new laws demanded that we do so in order to remain in business. In fact, it is our opinion that advertising would in fairly short order reduce the competition in our area. I can only speak for Perth Amboy. We have 10 pharmacies in Perth Amboy at the moment. There are no large chains within the city limits. But we have 3 large chains in our trading area, one less than a mile from it. With competitive advertising, I doubt if more than 3 pharmacies would survive out of the 10, although I must say, with due respect to Mrs. Annich, I am not going to try to protect a marginal operation that has been hanging on by the skin of its teeth and perhaps charging prices that are - and I will use the word that was used yesterday - unconscionable, because I really feel sometimes that there are unconscionable prices charged in pharmacy as in every other profession.

But I feel that few would survive the onslaught of the nearby supers or the 1 or 2 larger independents. As a matter of fact, this might be a very good thing for me. I am the largest independent in the Perth Amboy area. I would probably survive. I have no intention of not changing if you gentlemen decide that my profession shall change.

In the final analysis, I believe it is entirely possible and probabl that the patient might end up receiving less and paying more while the newspapers, radio stations, television people and the circular companies profited.

In March of 1974, our average prescription price was $4.66. These are exact figures. You are welcome to check them anytime in my pharmacy. That was our average prescription price a year and two months ago. In March, 1975, this figure had risen to $5.07. The portion of this price that we passed on to the consumer was only 9 cents while the manufacturers' cost to us for drugs rose 32 cents. This increase amounted to 4 percent in an economic period that reflected a rise in the cost of living in excess of 15 percent. Incidentally, this was our first fee increase in 4 years. The reason it came out to an odd amount is due to the birth control tablets. We didn't raise that at all at that time. So instead of it being a dime, it came out to 9 cents.

How will this proposed removal of the ban on prescription advertising bring down the cost of drugs to the patient? Some consumer groups and government people say it will bring prices down. These "experts" on pharmacy economics have yet, in spite of Mrs. Annich, to offer one iota of proof that this has happened in states that allow advertising. It doesn't affect what the manufacturer charges us. The reason I keep bringing in the manufacturer's price is because out of every dollar's net profit on a prescription, 80 cents accrues to the manufacturer. About 18 cents on every dollar of net profit comes back to the retailer and about 2 cents goes to the wholesaler or other middlemen who might be between the direct line and the retailer. Having the retailer increase costs by advertising will certainly have no effect on the manufacturers' chaotic prices.

However, I did not want to be just critical. I am sorry Assemblyman Herman isn't here because I really do think savings can be effected with the passage of Assemblyman Herman's 1257, the Drug Product Selection Bill, and its companion legislation in the Senate, sponsored

by Senator Zane.

In addition, we suggest that a sign be placed in every pharmacy, stating that "Upon request, you may have your prescription priced before you decide to have it dispensed."

Passage of 1257, in my opinion, will substantially influence drug manufacturers' pricing habits on multiple source drugs to the benefit of the patient. Now let me drop a little bombshell that I don't think any of you have heard before. We - this is myself and four other pharmacies in my county - have had a similar plan to Assemblyman Herman's drug products selection working now for a little over two years. We have gotten the prior authorization of physicians in each of our areas. I have approximately 41 physicians who have signed a contract with me whereby when they write a prescription and it comes into my pharmacy - they don't direct it to my pharmacy, but if it comes into my pharmacy - and it is written for any drug that is listed on our contract, I can interchange that for any other drug of like bio-equivalence that is also listed on the contract. We have, I think, 32 different companies listed on our contract. We have agreed if it is made by one company and it is also marketed by another company, we can give whichever one we wish.

The net result of being able to buy in quantity from one company on bid is as follows: In the first year of operation of this plan, for an anti-biotic prescription when it fit into that category, written by one of these physicians for a multiple-source drug, the average reduction in price to the patient was $1.25 from the year before. At the same time, the cost of living in this country rose 16 percent and we were down to $1.29 a prescription. We were still giving every service possible.

A sign in the prescription department should help prevent the occasional ripoff and satisfy the comparison shopper without materially adding to the prescription drug bill of New Jersey's consumers.

Part of this complex problem is an emotional one. Nobody wants to be ill. Nobody wants to be ill and be forced to pay for the illness also. If a patient is forced to purchase a prescription, which most of the time he is because one doesn't go in and get one because he wants one, no matter what the price is, it is going to be too much.

I have yet to hear a complaint from somebody saying, "I just spent $12 on a bottle of scotch." In fact, the liquor companies have proven that if you display three bottles of scotch and they are all identical except for the label, most people will buy the middle-priced one, and the next largest number will buy the high-priced one. The fewest people buy the lowest-priced one. Most people want the best liquor they can get. It is the same thing at Christmastime; I love to wait on people because they come into the store happy instead of sad. They like to buy cosmetics and they like to buy gifts, but people don't like to buy prescriptions. Whatever we charge is going to be too much.

The patient can't argue the price with the hospital. Although he can be angry, there is no one there he can argue with. And very few people challenge the doctor about his price. Who does that leave? Right across the counter, there we are.

Perhaps because of the media, perhaps due to political pronouncements, some people have become sincerely convinced that advertising and/or posting of prescription prices will lower the retail cost of prescribed medication without changing the availability of needed services and other facets of the current community drug delivery system.

I have just one answer to that, gentlemen and ladies, no way. You can reduce prices, but you won't have what goes with it.

ASSEMBLYMAN BAER: Thank you very much for your testimony.

Assemblyman Ruane.

ASSEMBLYMAN RUANE: Thank you, Mr. Chairman. Let's get back to our original point. I see that you do 64,525 prescriptions a year by my calculations. That is fairly accurate. Do you charge a minimum set fee of say $2 or $2.25?

MR. FELDMAN: We use a fee system.

ASSEMBLYMAN RUANE: How much do you charge for a prescription?

MR. FELDMAN: Our fee system at the moment, with two exceptions, is $2.35.

ASSEMBLYMAN RUANE: Then we could take 64,525 and multiply it by $2.25 ---

MR. FELDMAN: $2.35.

ASSEMBLYMAN RUANE: (Continuing) --- and we have the base that you start out from.

You tell us in your information here exactly how much profit you are making on your drugs. You have your profit going in; you don't need to make profit on the drug at all, right? How do you justify setting $2.35 per perscription? How does your industry justify that?

MR. FELDMAN: Let me ask you a question so I can answer yours. Will you define profit for me, please?

ASSEMBLYMAN RUANE: I would say profit generally is something over and above what your costs are.

MR. FELDMAN: Then you are talking about gross profit, aren't you? You are not talking about net profit.

ASSEMBLYMAN RUANE: I am talking about the profit you get over and above what you put into it. That is what profit is.

ASSEMBLYMAN BAER: May I interrupt for just a moment. Is there a confusion or a difference here between markup and profit? Is there any need for clarification on that?

ASSEMBLYMAN RUANE: Not unless you want it.

MR. FELDMAN: I will have to clarify it.

This is my certified statement from Moritz, Waldman, Green, Brooks and Company, Public Accountants, for the year 1974. The gross profit ---

ASSEMBLYMAN RUANE: I am not opposed to fair and equitable profit. What I am talking about is whereas I can agree with you that there is price-fixing by many pharmaceutical companies, per se, right across the board, you and your profession have instituted a similar type of arrangement by setting a fee.

MR. FELDMAN: That is not at all true, sir.

ASSEMBLYMAN RUANE: Yes, you have.

MR. FELDMAN: The only way that would be true is if we all set the same fee. That is what price-fixing is called. In collusion, if I got together with ---

ASSEMBLYMAN RUANE: I didn't say collusion.

MR. FELDMAN: I did. I used the word. If I got together with Mr. Brockman and Mr. Gervasi and we all got together and said, "This is what we are going to charge," that is price-fixing. But we don't do that. That happens to be against the law. The fee that I set in my pharmacy is what I unilaterally decided to charge in my pharmacy. This is what I need to stay in the black to run a viable operation.

A pharmacy across the street from me doesn't use the fee system; he uses a mark-up system. His prices are entirely different from mine.

ASSEMBLYMAN RUANE: Why? That is another good question. Why does the price vary so drastically from one pharmacy to another?

MR. FELDMAN: Do you want me to give you an answer to that, about the price across the street, or do you want me to go back to the first question.

ASSEMBLYMAN RUANE: Well, go back to the first question; then we will get to the other.

MR. FELDMAN: What you were talking about is what we call gross profit. That is the profit before you take into consideration your overhead, your salaries, your insurance. It is called gross profit on sales.

During the year 1974, we had gross profit on sales of $201,957. That is not going to gibe with the figure you have here because I gave you the current figure of how many prescriptions we are filling a day and this was a year and three months ago. But our gross profit on sales was $201,957 in the entire store, not just on prescriptions. Our net selling profit was $52,000. Then came a deduction from that of all general administrative expenses, and we ended up with a net operating loss of $8,727. The way my accountant does it, he then adds in telephone commissions, bad debts recovered, money order fees, telegram fees, interest income and everything, and I came out with a net income after sales, after taxes, after everything, of $4,059. That is my net income after everything. You cannot confuse gross profit with net profit any more than you can confuse my profit on sales, which is the result of income invested, with what I take as a salary because I also work on occasion when the Legislature is not in session.

ASSEMBLYMAN RUANE: I don't dispute your salary.

MR. FELDMAN: What I am saying is that they are two separate things.

ASSEMBLYMAN RUANE: What I don't like is the fact that you are fixing a set fee. I won't say price-fixing.

MR. FELDMAN: Yes, we are using a fee system.

ASSEMBLYMAN RUANE: I think that that lacks moral integrity.

MR. FELDMAN: Could you tell me why, sir?

ASSEMBLYMAN RUANE: Because it guarantees you a base profit of $154,00, according to my figures, and your payroll is $156,000, and it has nothing to do with any other items that you sell in your store. In other words, your profit somewhere along the line is made on, say, welfare recipients or the general public.

MR. FELDMAN: Certainly not on welfare recipients.

ASSEMBLYMAN RUANE: I don't begrudge you a fair and equitable profit. What I am saying is, if you take only two or three pills or ten pills prescribed by a doctor out of one jar and put them in another one and charge $2.35, that is guaranteeing you what I feel to be a disproportionate share of profit.

MR. FELDMAN: I think what you are overlooking slightly is everything Mr. Braverman testified about before as to what a pharmacist does.

Yes, you are right. Some pharmacists open up one bottle and count out the pills and put them in another bottle. When they try to read the doctor's handwriting on the prescription, sometimes they get it correct. They read the prescription and type the label and enter it on a family record card. They don't bother checking to see if there is any drug interaction and never call a physician to find out.

The last time we did a cost survey to find out what it costs us in our pharmacy on the average to fill a prescription was about two and a half years ago; so it doesn't hold anymore. The last two and one-half years our economy has certainly changed. The survey showed it costs on the average $1.89 per prescription. Whether it was taking pills from one bottle and putting them in another or whether it was compounding an ointment that took a half hour, it averaged out that it costs us in labor, delivery - all the things we provide - about

$1.89 per prescription. At that time, my fee was $2.10.

ASSEMBLYMAN RUANE: What was your average prescription at that time, $4.60?

MR. FELDMAN: I really don't remember.

ASSEMBLYMAN RUANE: You are talking about a 200 percent profit, if my calculation is correct.

MR. FELDMAN: No, you are talking about 100 percent gross profit. Most of the expenses that we bear in a pharmacy are directly related to the prescription department. We certainly don't pay a girl out front the same amount of money per hour that we pay a pharmacist.

ASSEMBLYMAN RUANE: Actually,my premise is this - and maybe you will agree with me: If we assume that there is price-fixing by the manufacturers and you set a fixed fee, you as an individual ---

MR. FELDMAN: Yes, I have.

ASSEMBLYMAN RUANE: The consumer then has no control over competition. For instance, by not going to you and going to someone else, he is going to pay the same price you are charging, give or take a few cents. In other words, the competition aspect has been completely negated.

MR. FELDMAN: But I just said the fellow across the street charges entirely different prices. He works on a markup.

ASSEMBLYMAN RUANE: My premise is that all across the board, starting from the manufacturers right down to you, the customer obviously has no chance at all. Whether he goes to your pharmacy or another pharmacy, he is going to get the same pricing. I am using a nicer word.

MR. FELDMAN: You mean if we all set the same fee.

ASSEMBLYMAN RUANE: What I am saying is that basic competition in your industry does not exist.

MR. FELDMAN: Then how did they get all those different prices?

ASSEMBLYMAN RUANE: It doesn't exist; it is a facade.

ASSEMBLYMAN BAER: That is Mr. Ruane's statement. Do you have any further questions?

ASSEMBLYMAN RUANE: No. My point is that I don't see where advertising would hurt the industry and I have given this considerable thought for the last three weeks.

ASSEMBLYMAN RYS: I have no questions.

ASSEMBLYPERSON CURRAN: Do you mind giving us a ball-park figure on the salary you take out of the pharmacy?

MR. FELDMAN: Not at all. This was in 1974 - $20,857.

ASSEMBLYPERSON CURRAN: What was the job you had that the Rite-Aid man now has?

MR. FELDMAN: I worked one-quarter time for the State of New Jersey as a pharmacist at the New Jersey Home for Disabled Soldiers in Menlo Park.

I talked myself right out of a job. I enjoyed doing this. It was sort of a break for me in a different type of pharmacy, but they needed more than one-quarter time. They expanded from 200 beds to 300 to 400 and I said, "You need real pharmaceutical services here. You shouldn't have a part-timer who comes in one day a week for eight hours or two four-hour days." I went down to Trenton and said it. They said, "We are going to do it. Would you like the job?" I said, "Not for what the State is paying." I didn't want that kind of a cut; I couldn't afford it. So I helped them get someone else to fill the job.

ASSEMBLYPERSON CURRAN: It would be interesting if we had the time to go into some of the questions we went into this morning in regard to institutions with

you. Thank you.

ASSEMBLYMAN BAER: You mentioned about your serving on the Board. Could you identify for the record what board? Were you on the Board of Pharmacy?

ASSEMBLYPERSON CURRAN: It is in the record.

ASSEMBLYMAN BAER: It is in the record?

ASSEMBLYPERSON CURRAN: He said it; it is in the record. He explained what he did at the Soldiers Home in Menlo Park.

ASSEMBLYMAN BAER: You have not also been on the Board of Pharmacy then. Perhaps I misunderstood. Thank you very much for your testimony.

Mr. Brockman will be our next witness.

Excuse me, Mr. Brockman; before you proceed, I wanted to ask Mr. Feldman to provide us with one thing. I am most interested in this voluntary program that you spoke of in your area. If you could provide us with full information on that, it would be very helpful. What I have in mind, if it is not private, is the contract that you have utilized, any rules or bylaws of whatever association you have. And if you can give me an indication of the percentage of pharmacists and the percentage of doctors that this group of 40, or whatever number you mentioned, involves in the area, I would appreciate it. I would be most interested in any information on this so we can determine whether this could be a pattern for anything elsewhere.

MR. FELDMAN: I certainly will. As you know, I worked with Assemblyman Herman for at least a year now, helping develop the bill and whatever I could do gathering information for him. This was part of his presentation and I will supply you with it.

ASSEMBLYMAN BAER: And, of course, also the list of drugs for which substitution was permissible under that. Whatever material you have will be appreciated.

H E R M A N B R O C K M A N: Mr. Chairman and ladies and gentlemen of the Committee: My name is Herman Brockman. I am a retail pharmacist in Bayonne, New Jersey, representing myself, the Bayone Pharmaceutical Association and the Hudson County Pharmaceutical Association.

I want to thank you for giving me this opportunity to testify before your Committee.

I believe strongly that these two bills should not be enacted into law. I hope I can give you a few of my own reasons why.

You may or may not be aware that we are one of the few professions that have continued education to renew our license and we are 100 percent in favor of this. We backed it when it became a mandated law in the State of New Jersey. It is a practice which keeps every pharmacist in the State of New Jersey up to date in just about every aspect of his profession. I personally believe that all professions should have it.

But since we do have this requirement and we are treated like professionals on one hand, I cannot see why we should be treated like ordinary businessmen and forced to advertise and compete with people with whom there is no way in the world we can compete and stay in business.

I think we should maintain a professional image the same as doctors, dentists, accountants, and veterinarians, none of which have any continued education. There has never been any talk or controversy about posting of fees for any of these other professions or advertising. If we take surveys of any other profession, we are still going to find quite a difference in prices. We are always going to have good and bad in every profession and we are always going to have a high price and a low price.

However, if you take the particular survey that Mrs. Annich did of the drugs involved and if you look at

the average price in every case and if someone were to supply you with the information of the cost of each ingredient, you would find out that every price averagewise is more than fair.

In cases of emergency, if you had to get hold of your doctor, your dentist, your lawyer, your accountant or your pharmacist in the middle of the night, I would venture to say that the one most readily available and the one you would definitely be able to contact would be your pharmacist.

Blue Cross and Medicaid which have their prescription plans have seen fit to raise the professional fee to the pharmacists because of two reasons: one, his service. Any patient who has a prescription filled can call you up at any time during the night if he has any kind of problem or emergency and you have to be available. The second reason was for consultation. If any person comes into your drug store and wants professional advice, anything to do with his prescription or his ailment, you have to be available to speak to him - not a high school clerk or an older person who is working part time, but you, yourself, have to be available for consultation. Blue Cross has recognized this and increased its dispensing fee.

The patient profile system, I think, has been spoken about enough, except for one item. Mrs. Annich claims that it is useless because everybody goes to different drug stores. I think that, if any survey is taken, you will find that over 80 percent of the people utilize the same drug store most of the time. Therefore, the prescription profile system is of value.

I would like to cite something that happened in my drug store. Over the past two months, I had three emergency calls in the daytime from physicians to dispense a product called syrup of ipecac, to rush it immediately to three houses where on three different occasions a child

had swallowed a drug which was very dangerous to his health. I immediately filled the prescription, rushed it over, and the child, when he takes this particular syrup, vomits and any poisonous substance comes out of his system.

The type of operations that these bills are going to promote can in no way perform this service. In the first place, the so-called discount stores do not even carry a product such as syrup of ipecac in stock. Number two, they don't deliver. Number three, if it was one of the four nights a week that the so-called discount store in my town is closed, they couldn't even reach the pharmacy. So the person involved would have to take his child to the hospital for emergency treatment because there is no way he could leave the child home and go to a store himself. This is something that happened three times in the last two months in my own store which indicates to me that laws like the ones proposed are just not made for the safety and welfare of the public involved.

Discount stores are now in just about any city for those looking for them. They have disadvantages. They do not fill any compounded prescriptions. In our City of Bayonne, we constantly get prescriptions with the number already recorded on them from the so-called discount store in the center of town, where the girl takes the prescription from the patient, stamps a number on it, and when it gets to the pharmacist, he says, "We can't fill this; we don't have it." He gives it back to the girl and she gives it back to the patient. Then they bring it to the local pharmacy. When we see the number, we automatically know they went there first. We ask the person, "What was the matter?" They say, "They told me they didn't have it; they couldn't fill it," or whatever the reason.

This is something I think should be looked into because a drug store is supposed to fill every prescription to the best of its ability. When a drug store constantly,

maybe a hundred times a month, tells a patient, "We don't have the preparation," something is the matter.

They give no services. They have no delivery service. They carry a limited inventory which is another reason they give back prescriptions. With this limited inventory, if you go back there for a refill prescription, whether it is nitroglycerin for a heart condition or a tranquilizer, if they are out of the particular item, they just hand it back to you and say, "Look, I'm out of this now; I'll have it in two or three days." If you can wait two or three days for some medication, it is all right, but a lot of people can't. You usually have to wait for a prescription either an hour or two and you browse around, whether it is a food store or a general merchandise store, and they hope you buy enough other merchandise to offset the loss-leaders in the drug department.

As far as price goes, any person can walk into any drug store and say to the pharmacist, "Could you tell me how much this prescription will cost?" It happens every day of the week in my store. Once in a while a person will say, "thank you," and take the prescription back and go someplace else. But most of the time, they say, "Will you fill that for me?" So it is not a question of the pharmacist saying, "No, you can't have a price on a prescription."

The government in the past four years has passed numerous laws to stop drug abuse and placed strict controls on amphetamines, barbiturates and now is trying to put the same controls on the most widely prescribed tranquilizers. These are very strict controls. There is a lot of book-keeping involved, and I think they have helped quite a bit to curb overprescribing. They also apply to any preparations containing codeine. I cannot visualize how the government on one hand is trying to place strict controls on these items and yet on the other hand we are going to be able to

have these items advertised in the newspapers, on radio and television, anywhere you want to, telling people, look, you can buy these particular items cheaply if you can get a prescription from your doctor. I don't understand how this can be permitted at a time when the government says drug abuse is one of the largest problems we have and is trying to put on controls so that the number of these products used is cut down.

In the last two years, over 1400 independent drug stores have gone out of business across the country. These bills certainly are in favor of large businesses and discount drug operations and they will further increase the number of independent pharmacies who will fall by the wayside.

These bills will also discourage young people from going into pharmacy when they see what is happening and will create a worse shortage of pharmacists than now exists in most areas.

The average family spends $75 a year for prescription drugs. This is probably the cheapest part of their overall health care. And I really don't think it is an excessive amount.

When it comes to pricing, I, myself, do not use a set fee as was just testified to by Mr. Feldman, and very few stores in the City of Bayonne do. The only set fees I have in my store are the ones that have been dictated to me by the government - that is, by Medicaid. They came to me and said, "You have to charge a $2.15 fee for this prescription whether it costs you 27 cents or whether it costs you 27 dollars." And I have had a few that cost 27 dollars and I still get $2.15. The same is true of Blue Cross, which has taken a survey and said, "We feel this is a fair fee; therefore, you have to charge this fee, no matter what the cost is to you," and also of other prescription plans. These are the people who have

set the fees in my store, not the pharmacists working together or price-fixing. If a government agency tells you how much you can charge, you can bet your life they are not giving you more than you are entitled to.

In connection with this $2.15 fee, I might say that I only employ one full-time pharmacist in my store besides myself and he costs me $10 an hour. That is 17 cents a minute. If he fills a routine prescription with all the paper work and it takes him 10 minutes to do it, that is $1.70 I have to pay him. If the prescription costs me $2 - say it is a Medicaid prescription and I get $4.15 - that is $2 plus $1.70. My gross profit on that particular prescription is not $2.15, but 45 cents. On other prescriptions where the cost is cheaper, I use no fee at all; I use a fair simple markup which comes to a lot less than a fee in some cases. Maybe in a real expensive product, it might come to a little more than a fee. I really don't think a fee set by Medicaid is excessive and I don't think you gentlemen really do either.

When it comes to price-fixing, we have discussed this numerous times at different meetings and told the people outright: it is collusion; you would just get in trouble; and it is not to anybody's benefit.

I think most drug stores are more than fair in their pricing. If the majority of drug stores charged a high price, you could never get in any survey an average price, such as for lanoxin, which Mrs. Annich mentioned cost $1.20 a hundred. If you buy it in larger quantities, it brings it down to about 80 cents a hundred. If you took 80 cents plus the $2.15 that the government says you are allowed for Medicaid welfare prescriptions, that is $2.95. Her average price was $2.65. Orinase was another product mentioned. If you buy them by the thousand direct from Upjohn, the best price you can buy, no middleman no wholesaler, they cost you $7.90; that is, per thousand, direct

from Upjohn. If you add $2.15, which again is the amount that Medicaid says you are entitled to, it comes to $10.05. Her average price was $9.95, I believe. It was under $10. I could be wrong on that. I think it was $9.95. I think the other one she had was polycillin and, if you add the costs involved, it comes out in the same range.

So I think the average price shows that at least 80 to 90 percent of the drug stores have reasonable prices. And the few who are out of line and are charging exorbitant prices - I agree there should be some way they should be stopped, but not through advertising. Maybe it could be done through some kind of peer review or review by a State agency. They are definitely in the very small minority. I don't believe the entire industry in which most pharmacists average 55 to 60 hours a week minimum should be penalized for the few people who are charging outrageous prices.

ASSEMBLYMAN BAER: Thank you for your testimony. I have two very brief questions.

When you speak about 1400 pharmacies going out of business nationally, do you know what the figure is for the same period of the number of pharmacies opening up?

MR. BROCKMAN: No, I don't know the number. But the statistics showed there were 1400 less pharmacies in the country.

ASSEMBLYMAN BAER: Then that was a net drop.

MR. BROCKMAN: That was a net drop. There might be more that went out of business and some new ones that came in, but that is the net drop. I think that is about 3 or 4 percent, which is for one year.

ASSEMBLYMAN BAER: Thank you for clarifying that.

You suggested that we look into the problem in terms of the lack of selection in some of the stores.

I would like to ask you whether you feel that legislation or regulation is feasible to mandate a full breadth of selection for any store or pharmacy that is operating, regardless of its type. Is it feasible, given the changing nature of drugs, to do this? Can the Board keep up with it? Is it something that might be desirable to do?

MR. BROCKMAN: Do you mean substituting?

ASSEMBLYMAN BAER: I am not talking about substitution. I am talking about regulations that might mandate the minimum breadth and scope of selection of drugs that a pharmacy would carry.

MR. BROCKMAN: I don't think it is possible because there are probably 30 or 40 thousand different drugs. All the products are now dated; all the companies have dated them. But I have drugs in my store I might use once a year. It would be very difficult to pass any kind of legislation or have any kind of committee mandate every particular drug that could be carried in a store.

ASSEMBLYMAN BAER: I didn't say every one that could be carried. I raised the question about every one that should be carried because you have commented about some stores having too narrow a selection.

MR. BROCKMAN: Right.

ASSEMBLYMAN BAER: Obviously nobody would ever want to mandate that everything that was ever produced be carried.

MR. BROCKMAN: Yes, but how can you set up what drugs should be carried and what drugs should not be carried? There may be one particular doctor who thinks one drug is the greatest drug in the world and he treats his patients with it, and there might not be another doctor in the State of New Jersey who prescribes that particular drug. How could any Committee come up with a list of drugs that should be carried? I don't think that this is possible. I don't think I, as a pharmacist, could come up with a list.

ASSEMBLYMAN BAER: All right. You have answered that question.

You made reference to the fact that at some meetings of pharmacists, there were some pharmacists proposing agreement on prices or price-fixing until you explained to them the illegality of that.

MR. BROCKMAN: No, I didn't say that they ever proposed price-fixing. I said when we have sat down and discussed different products and different prices that drug stores receive for those products, there has been a variation. We have recognized if there wasn't variation, then we would be accused of price-fixing. We never spoke of any price-fixing. It was a topic of conversation where it was pointed out that there is variation in prices from store to store and, if there was not, we certainly would be accused of collusion and price-fixing.

ASSEMBLYMAN BAER: Perhaps I misunderstood. I thought you said that there were some that were proposing this.

MR. BROCKMAN: No.

ASSEMBLYMAN BAER: I have no further questions.

ASSEMBLYMAN RUANE: You seemed to imply something and I would like to have it clarified. Are professional people above the free enterprise system?

MR. BROCKMAN: No, they are not. I don't think they are above the free enterprise system. But I also don't think that a professional person should have to try to compete with giant monopolies. I honestly believe,when you pass a law that is going to allow price advertising, that I cannot compete with Rite-Aid, Pathmark, Shop Rite. I know I cannot take a $500, full-page ad in the Jersey Journal of Hudson County and list 30 fast-moving drug items at cost or at a few cents below cost. I can't afford this; they can. They write it off in their general budget just

like they do 30 food items.

The point that I am making is that I don't think it is possible for the professional people to compete with the multi-million-dollar giants.

ASSEMBLYMAN RUANE: I sympathize with you as a small pharmacist.

Let me ask you this: Isn't there a code of ethics promulgated by the Board of Pharmacy or some agency which would declare certain things unethical?

MR. BROCKMAN: Yes.

ASSEMBLYMAN RUANE: Maybe you have that currently. You see, that is the apple. What we have been talking about here at times today is apples and oranges. How will advertising affect your profession? You are giving other reasons than I would normally think should be given. If they misrepresent a product or a company name in the newspaper, couldn't your own Board of Pharmacy call that unethical?

MR. BROCKMAN: No. They won't misrepresent. They are just going to say, "We will sell you 100 valium tablets for $6.95," even though it costs the average pharmacist $8.00. We can't stop this.

ASSEMBLYMAN RUANE: Couldn't you prove that selling a hundred pills might be dangerous?

MR. BROCKMAN: No.

ASSEMBLYMAN RUANE: Couldn't you at least suggest it?

MR. BROCKMAN: No, because the doctor writes a hundred pills for a maintenance dose of a product for a patient all the time. Take a person who takes a diuretic like Liuril for hypertension, or a diabetic who takes Orinase, or someone who takes Larodopa for Parkinson's Disease; the doctor will write 100 at all times for these people because it is much cheaper for the patient in the long run. But there is no way I can make the State Board of Pharmacy or any State agency say to a large chain,

"Because you are giving these loss-leaders away at a below-cost price, we can prosecute you or stop you." There is no way it can be done.

I don't know the answer to that.

ASSEMBLYMAN RUANE: It is very frustrating.

MR. BROCKMAN: It is. All I know is that we have one in Bayonne right in the center of town. He is doing a tremendous business without giving any service. In the City of Bayonne we have 14 small drug stores now, besides the one large one. I am firmly convinced that 50 to 75 percent of these stores will definitely be put out of business by this advertising bill because there is no way that they can afford to compete with the big chains. They will just take the money as part of their national budget and spend it on advertising and get the people in on their loss-leaders. Then, as Mr. Salkind, I believe, said yesterday, three years from now, the cost of prescriptions is going to be much higher than it is right now. I think our Association has shown with the statistics it has provided of Pennsylvania that the year after prescription advertising became legal in Pennsylvania, there was a sharp rise in the price of prescriptions. The average price of prescriptions in New Jersey right now is still cheaper than the average price was even before they started advertising in Pennsylvania and now is cheaper than the price in Pennsylvania where they do have advertising. I really don't see any benefit from it.

ASSEMBLYMAN BAER: Mr. Brockman, I want to thank you very much for your testimony.

Mr. Nawrocki. First of all, Mr. Nawrocki, I want to apologize to you for the fact you happen to be the last man and commend you for your patience in waiting through all this testimony until you had your turn. I noticed from your facial expressions today that it has

been very frustrating at times not being able to comment as things have been said. You have wanted to give us your testimony; so why don't you proceed.

T H E O D O R E N A W R O C K I: First, I would like to tell the Committee how much I appreciate the fact that you are holding these hearings and giving the pharmacists an opportunity to tell their side of the story. We have a lot of misconceptions in the minds of the public and legislators about what the whole thing is all about.

I am Theodore Nawrocki, a community pharmacist from Union, New Jersey, and a trustee of the New Jersey Pharmaceutical Association.

Some of the comments I make here come as a community pharmacist actually.

I would like to speak in opposition to the prescription price advertising and posting bills: A 1228, A 3273 and A 736.

The average pharmacist has been bending over backwards trying to provide prescription drugs to the public at a reasonable price. The record shows that the cost to the public today for a tablet or a dose of medication is almost exactly the same - this is up to a year ago when the study was made - as it was ten years ago. This was documented in the Firestone Study, at the City College of New York. I could go into further detail on that later if you would like, but I want to hit the more pertinent issues.

It was brought out that prescription costs are soaring, and rightly so. The reason for this is primarily due to the introduction of new and more effective drugs, control of certain chronic conditions and, especially, the passage of the Medicare program in 1965, which enabled elderly people to get medical help for the first time. These people are seeing doctors, are being hospitalized, are being treated properly, and, naturally, are using more prescriptions. So it is a total of more drug utilization

rather than increasing costs. And this is all documented.

In the last ten years, we have seen some ten or twelve thousand community pharmacies forced out of business. Those of us who have survived have seen our net profits on sales decline to the lowest point in history. Our employee pharmacists, even though they have a five-year college education requirement, make less in salary and benefits than the auto workers, as I understand. So we are not getting as rich as some people think. Even in spite of this, we are being told by certain governmental officials that there is not enough price competition at the retail level. It is unbelievable. My assessment of the problem is as follows:

I disagree with Martin Feldman to a certain extent. I don't think the problem is the people don't want to buy prescription drugs. It is a little more complicated than that.

For the last 15 years, pharmaceutical manufacturers have been attacked in the press and other media, and rightly so; that is, ever since the Kefaufer hearings. There are going to be more attacks. As a matter of fact, there is one being worked up right now in Washington and I am working with a committee down there on this attack. The public has read enough headlines to convince them that there are immense profits in prescription drugs and that many prescription drugs are grossly overpriced. There are immense profits and many prescription drugs are overpriced. Only the pharmacist knows that it is not he who is making these immense profits. Many of these drugs are grossly overpriced before we add as much as a penny to the price we pay for them as our charge for dispensing them.

What has created our immediate problem is that numerous price-shoppings show that the price of one certain

prescription might vary between pharmacies. These shoppings have misled the public into thinking that it is the pharmacist who is primarily responsible for the high prices they pay. Or perhaps, they view us as working hand in hand with the manufacturers and not in their interests. In any event our image has become tarnished and our credibility almost totally destroyed.

As a member of the Economic Interest Committee of our State Pharmacy Association I felt it was my duty to spend considerable time on this problem and that is why I am here today. I want to try to clear up some of the misconceptions about the pharmacists' pricing practices and explain that there are legitimate reasons why the price that a pharmacist might charge for one certain prescription might vary. One such reason is the type of pricing system a pharmacist utilizes in his practice.

Prior to 1965, our associations were allowed to distribute prescription pricing schedules so that there would be uniform prices at the retail level. In 1965, the Anti-Trust Department of the U. S. Justice Department ruled that this was in violation of the Anti-Trust laws and stopped this practice. They felt that each pharmacist should adopt his own unique pricing system. Under these conditions you could not expect that prices would be uniform now - some ten years later. But the one factor that created some disparity in retail prices was the emergence of a totally new pricing system during this period. This is the fee pricing system, whereby a flat charge is made on each and every prescription so that each and every prescription carried its fair share of providing prescription services to the community. Originally, it was developed in Canada. What is a fee system? In Canada, some pharmacy students threw out a suggestion to a Professor Fuller at the University of

Toronto.

ASSEMBLYMAN BAER: May I break in a moment. I am a little bit concerned about time. I think we know what the fee system is. I have been noticing as you read from this 12-page statement you add inserts that aren't written here several times on each page. It has taken about 10 minutes for the first two pages. On that basis it would take an hour to complete the whole statement. We will read the statement carefully. I am wondering if you could hit the highlights and avoid things such as explaining the fee system, which we understand.

MR. NAWROCKI: Well, the fee system is an improvement over all the other markup systems. I could go into further detail. It has been recognized as such by the federal government and all State agencies. In New Jersey, we realized we had to respond to these variations in prices, so we suggested that all pharmacists seriously consider adopting such a system. This action was implemented and pushed. Now the State of Virginia is doing the same, as is California. And I just got a letter from the American Pharmaceutical Association saying they are going to push it nationwide too. The reason we are doing it is that in Canada all pharmacists use a fee-pricing system. There is no such thing as markup in Canada anymore. Prices up there do not vary as much as they do in the United States because everybody uses the same type of pricing system. So that is one of the reasons that prices vary, which wasn't brought out before in these hearings.

Then, of course, you have the services of the pharmacists; that we went into pretty fully.

The differential price problem is another one. Use of generic drugs is another factor. The use of loss-leader items by the discount pharmacies is another factor which influences the price variations.

One thing about the loss-leader aspect is this: With posting - and I wouldn't object to posting ---

ASSEMBLYMAN BAER: You don't object to posting?

MR. NAWROCKI: I wouldn't if it was done on a basis similar to what they have in Canada. In Canada, a discount prescription store will use a $2 fee on every prescription. The community pharmacist naturally has higher costs and he uses a $2.60 fee on every prescription. So the public sees there is only a 60 cents difference - and that is what it actually is - between a chain and a community pharmacy. So they say, "For 60 cents it is silly to wait in line and do without services."

In the United States with this promotional device they have used, the posting isn't used as a factual means of communication. T. Donald Rucker, former chief of drug studies in the Social Security Administration, stressed this problem in a speech before the American Public Health Institute. And I have a copy of that speech. He brought out that the discount outlets were using the ability to post as a promotional vehicle. It deliberately misleads the public as to the true nature of the outlet's charges. They will post 100 prescriptions at cost or 10 percent above cost. And,in our area, we found the stores that do this charge as much as $3.50 over cost on items that are not posted. That is one of the problems. It is very difficult to communicate effectively to the public because of our credibility gap with the public.

We have been told the people have a right to know - posting - but actually can anybody judge? Part of the prescription price represents the pharmacist's charge for dispensing it. There is no way to judge the value of that part of the prescription; like any other profession, it is impossible. If a lawyer says, "I am going to charge $100," you don't know what you are going to get for that

$100 - or a physician. This is the reason no profession allows price advertising as a means of building a clientele. Not that it is not classy, it is just that it is simply too easy to mislead the public as to what quality service you are giving. And the only direction that profession will go into will be an increase in price competition; a lowering of standards; and, in some cases, it is detrimental to the public health. In prescription drugs, it is definitely detrimental to the public health.

One thing I wanted to bring out about price-posting, price-posting will encourage advertising or price competition on a broad range of drugs. Currently,we recognize that the main problem with prescription drugs is the elderly. These people are living on fixed incomes. They use up normally large amounts of prescription drugs. What many of us have done in New Jersey is have special senior citizens plans. We dispense these drugs at the lowest possible cost to these people. Some of us don't make one penny profit on these particular sales.

An increase of price competition on the broad range of drugs,with our profit margins being what they are now, we will have no alternative - and I have heard this from many pharmacists - but to discontinue these special programs. The one segment of the population that most desperately needs help will be hurt. That is another reason I don't like this posting.

We have recognized the problem of senior citizens. We have pushed for a Medicare prescription program and in New Jersey we pushed relatively successfully for catastrophic pharmaceutical assistance.

I would like to point out that T. Donald Rucker, former chief of drug studies in the Social Security Administration, prepared a position paper showing that too much emphasis is given to reduce prices at the

retail level. There are excesses at the manufacturers' level which cry out for correction. Senator Gaylord Nelson was supposed to have hearings start right now on the prices and profits of manufacturers. But because of the MAC problem with HEW, he has put it off, I think, until this fall. And I think the public and the pharmists are going to learn a lot about what is going on at the manufacturers' level. There will be quite a big change.

I would like to make a few comments on presentations made by previous speakers.

Mr. Givens of the Federal Trade Commission stated that approximately 300 million dollars a year could be saved if the advertising of prescription drugs is allowed. The total net profits of the 40,000 community pharmacists in this country are but approximately $350 million. As this figure is equal to 11 percent yearly return on the invested capital in these pharmacies, which is about 2 1/2 percent better than could be obtained on risk-free bonds, you can see the savings will not come out of profits. Certainly savings can be made. There are many ways of reducing prices: reduction of inventory, discontinuing of services. So, in effect, he is telling the public that they should give up quality services that protect their health in order to save.

Interestingly, Mr. Givens states that the people cannot afford medication and this is the reason they are interested in pharmacy advertising. For the record, the Portland Retail Druggists Association for the past four years has been trying to get the Federal Trade Commission to enforce the Robinson-Patman Act which pertains to the price differential problem, whereby manufacturers sell to hospitals for up to one-tenth the price they charge us. The Federal Trade Commission did not budge on this. The Portland group, due to a drive throughout the country, has just been supported by both of our national pharmacy associations. They are

going to support them with legal and financial aid. It is an all-out drive. Legal action has been instituted against 11 manufacturers to correct this. The Federal Trade Commission has done nothing, as I understand it, to correct a critical problem.

So if they are so alarmed about people not being able to afford medication, why haven't they moved in this direction?

Another action the Portland group has taken - they have found that in violation of Robinson-Patman manufacturers give special price concessions to chains. This is another law suit they are instituting. I just got word yesterday from Washington that our national pharmacy association, the American Pharmaceutical Association, might institute a separate action,with the prestige of the American Pharmaceutical Association with some 60,000 members, to attack the manufacturers. We have waited too long and we want this problem corrected.

Mrs. Annich claimed that advertising or posting could not encourage people to purchase large quantities of drugs. She claimed that physicians would exercise their judgment. But she forgets physicians are human. They have no alternative but to respond to pressure from their patients. Now, one of my patrons committed suicide last week. This patron's wife was very price conscious and she demanded that her physician prescribe everything in hundreds. Even though she only had a half a bottle of each of her medications on hand, that was sufficient. He decided to take the easy way out. It is just like leaving a loaded gun in the house to have too much medication around.

Mrs. Annich said that there is no fear that pharmacists will dispense in such a way that it will be detrimental to the public's health. The Board of Pharmacy, she claims, will make us comply.

Five years ago, the pharmacist was thought of as one who counts out a few pills; and, in truth, we did little more at that time. However, in the ensuing period, there has been a dramatic change in pharmacy. Now the primary emphasis is on the field of supervising the patient's drug therapy. We have found these prescription drugs are so potentially dangerous that it is vitally necessary for us to move in this direction. It is an entirely new ball gane.

The Board of Pharmacy of New Jersey is one of the most progressive in the United States, but they have not been able to keep up with the progress that is being made in pharmacy, and it is almost impossible to regulate a profession, especially one that is undergoing dynamic change and is moving so fast in a new direction.

You mentioned before, Mr. Baer, that there should be certain criteria for regulating a profession. We just had a discussion at the Pharmacy Convention — and this was by Dr. Brook of the Rand Corporation, Santa Monica, California. He is involved in setting up standards for assessing the quality of care given in federal programs. This is what he had to say about pharmacy: "There is no doubt that pharmacists can play a major role in preventing adverse drug reaction. It is time to develop an acceptable framework, constructs and indicators for assessing the quality of pharmaceutical care." In other words, the guidelines have not been set up. It is that new.

According to Mrs. Annich's statement, if we are going to abide by just the Board of Pharmacy rulings, pharmacy will take a giant step backward, and I don't think the public will buy this position. In fact, I know they will want to become educated about the pharmacists.

I am going to skip over some of these comments.

ASSEMBLYMAN BAER: Let me say that I have observed you making notes on your statement throughout the day and I can see from here that you have added a lot of material. If you would wish us to include the statement in full, with all the material added, as opposed to the form in which you distributed it, please get it to us and we will see that it is put in the record that way.

MR. NAWROCKI: May I finish this?

ASSEMBLYMAN BAER: Yes. I did not mean to cut you off.

MR. NAWROCKI: While mandatory price posting might possibly seem like a solution in correcting certain abuses of an extremely small number of pharmacists, I feel it would lead to a situation which would be detrimental to the public's health.

As I look at the entire picture of the community pharmacist, as one of the leaders in pharmacy - I am a trustee of Union County - I will tell you the main problem in this State is that people are being hospitalized and dying because every pharmacist is not utilizing his knowledge of drugs to the fullest in protecting the public's health. That is a real problem.

You might have gotten the impression from previous speakers that the professional services they render are rendered by every pharmacy; they are not. For years, the pharmacist took pride in his expertise in compounding prescriptions. But now this new frontier has opened up and it has only been within the last five or ten years that this is happening.

You have heard before that a million people are hospitalized a year due to adverse drug reactions, and this is the problem and this is the reason we are moving with the patient profile and checking for drug interactions.

We are attempting to get every pharmacist to move in the direction of upgrading his professional services. Unlike the optometrists who have been making

steady progress from year to year, what we have done here is taken a profession that is oriented in one position, grabbed them, turned them around, and said, "This is the way you are going to move." When this has happened in the past, according to one expert in the field, Donald Frankey, it has taken generations before the men in that profession moved in the new direction with any amount of force. We don't want it to take generations; we want it done as soon as possible, within the next few years at the latest.

We have the patient profile. That means almost nothing. It is only the first step. We have to educate the pharmacist. We have to get him to know what drug interactions are, drug food interactions, so he can warn people about side effects. It is a whole spectrum of services and we have to get each pharmacist to be motivated enough to study it and communicate with the public.

As a matter of fact, in New Jersey we are launching a program very shortly which will educate the public; because we have found that once the public is educated as to the true function of the pharmacist and how important his services can be in protecting health, the people will demand those services. It is not the whole answer, but it is going to make a big difference. We used it in Union County and it was very successful. We want these pharmacists to respond and move in this new direction.

The problem with price-posting is that, in effect, you will be throwing a monkey-wrench into what I visualize as the direction pharmacy should be moving. Currently, there is a credibility gap between a pharmacist and a patron. He is viewed as getting filthy rich, counting out a few pills. He could communicate with the public and try to explain something, but they don't want to listen. Their minds are made up that this guy is a crook and he is just trying to justify what they consider an overcharge.

With some pharmacists using a markup and some using a fee, until this is all straightened out and they are all on a fee system like they are in Canada, there will be questions about why the prices vary. The average pharmacist has maybe a 20- or 30-second time exposure per patient. I would much rather see him using that time - and we did this in Union County - specifically to warn the patient about potential side effects and ask them about other health ailments, using the patient profile card, rather than talking about the price of prescriptions and why they vary.

You saw the information I have here. It takes about ten or twelve minutes. No pharmacist can communicate it. The net result will be when those signs go up - and I feel certain of this because I have seen it happen in Boston --- I was talking to the Secretary of the Boston Pharmacy Association. At first, everything was fine and rosey, but then people started looking at prices, the chains moved in, and the fellows started to compete on a price basis. The way they did it, naturally, was to cut back on professional services. I think you are aware how important the professional services of pharmacists are. Don't let that happen to the people in New Jersey. (See page 31 X.)

ASSEMBLYMAN BAER: Thank you very much for your testimony.

Are there any questions?

ASSEMBLYMAN RYS: I was very much surprised you used the word "incompetent" with regard to pharmacists in the State of New Jersey. Do we have such animals? I know it is late, but I would like to have that clarified. If we do have such people, they should have their licenses taken away.

MR. NAWROCKI: They comply with the regulations of the Board of Pharmacy, period. That is not anywhere near what ---

ASSEMBLYMAN RYS: You are not answering the question. They may have qualified for their licenses, but are they competent in compounding drugs?

MR. NAWROCKI: Compounding of drugs is something the old pharmacists could do. They could compound drugs maybe better than some of us. But we have to move them in this new direction that pharmacy is taking. The new college students coming out are fantastic. They know all these things. But 80 or 90 percent of your pharmacists graduated 10 or 15 or 20 years ago. We have to educate these fellows. We have to make them realize how important their services are in protecting the public's health.

There have been some malpractice suits. As a matter of fact one was a case where it was alleged that the pharmacist did not warn the patient that with Declomycin she should not stay out in the sun too long. There is a photo-senstivity reaction. There are about 12 drugs that react like this and, if you are taking them, you shouldn't get out in the sun too much. It is a $60,000 malpractice suit. The courts have recognized that pharmacists share responsibility with the physician.

ASSEMBLYMAN BAER: To bring it down very simply, are you saying that the present regulations are not adequate to insure competence? Are you saying there are persons who are incompetent, but they comply with the regulations?

MR. NAWROCKI: They comply with the present Board of Pharmacy regulations. As a matter of fact, there was a statement by Aaron Silnutzer, who was just leaving the Board of Pharmacy after five years, in the New Jersey Journal of Pharmacy, and he stressed that we have made terrific progress in New Jersey. You know New Jersey is the most progressive state in the United States as far as motivating pharmacists in this new direction. But he still said - I forget the exact words - that we have

a long way to go.

ASSEMBLYMAN BAER: Are there any further questions?

ASSEMBLYMAN RUANE: I would like to ask you: How widespread is the senior citizen discount?

MR. NAWROCKI: It is getting more and more widespread every day. Because of the problem they are having, I would say there are at least one or two pharmacies in every town who offer senior citizen discount programs.

ASSEMBLYMAN RUANE: Is the Pharmaceutical Association promoting that idea? Is it part of your statewide promotion?

MR. FELDMAN: Yes. Could I answer that. I helped originate this. We started two days after Governor Cahill came out with that plan.

ASSEMBLYMAN RUANE: I will talk to you later about that.

MR. FELDMAN: All right.

ASSEMBLYMAN RUANE: My second question: Isn't it true that the compounding of drugs is a diminishing practice?

MR. NAWROCKI: Year by year.

ASSEMBLYMAN RUANE: Aren't most of your pills compounded by the manufacturer now?

MR. NAWROCKI: Yes. Only about 5 percent of the prescriptions require compounding. It is getting less and less important every year.

ASSEMBLYMAN RUANE: Do you feel the actual price-setting per perscription will help the consumer in the long run?

MR. NAWROCKI: I don't follow you.

ASSEMBLYMAN RUANE: The Canadian system.

MR. NAWROCKI: The fee system? Well, the United States government ruled that. They decided that years ago. They said the fee system is the most equitable.

ASSEMBLYMAN RUANE: The United States government isn't always right either.

It seems to me something needs to be done as far as the price of prescriptions is concerned because that is a set fee, the wholesale price of the drug to you is another set fee, and then there are whatever other costs you care to add on. So you can see the rising price. But I wonder how you justify the set fee, the $2.15 or the $2.35.

MR. NAWROCKI: How we arrive at that fee - and I am also involved in this nationwide because under the National Health Insurance ---

ASSEMBLYMAN RUANE: As I see the fee, it is simply nothing more than a sales tax, a regressive form of taxation, on the average customer because it is charged equally across the board to the indigent and to the rich.

MR. NAWROCKI: Would you have us charge according to their ability to pay?

ASSEMBLYMAN RUANE: How do you justify the discount to the senior citizens?

MR. NAWROCKI: Well, we have to do something for them.

In my pharmacy I have an operating cost of $2 a prescription. My senior citizens get their prescriptions for $2.10 a prescription; my usual fee is $2.60.

The way we determine the fee is we add up all our costs and we determine how much of that is incurred by the prescription department and how much time the pharmacist spends in the prescription department. Then we divide that by the number of prescriptions we fill a year. That is how we determine what the fee is in my pharmacy. In each pharmacy it will vary according to the number of prescriptions that are filled and the costs. That is why it is not illegal under the anti-trust. If every pharmacist said the charge would be $2.53, that would be illegal. The fee has to be determined by the individual pharmacist.

ASSEMBLYMAN RUANE: Thank you.

ASSEMBLYMAN BAER: We want to thank you very much.

I would like to state that I think this hearing has been a very valuable one. I think we have had a great deal of evidence and facts presented to us.

I do want to state that I have one regret about this hearing. Although we have had witnesses of very great technical expertise with credentials representing all the various professions involved, and all of these witnesses have testified from the point of view of the public interest, we have had to the best of my knowledge not a single representative of a consumer organization or a single witness here who is a consumer, himself, just testifying without having had any professional or other involvement of that nature, letting us know how he sees the matter. I regret that a hearing on such an important matter as this has not produced such testimony. I hope we continue to search for that information before we make a final decision on this matter.

Again I want to thank all of the witnesses for their assistance and also all the persons who helped the Committee in preparing its record.

The hearing is adjourned.

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13:33-1.38 Minimum standards and tolerances

SUBMITTED BY MR. HART

(a) Every prepared pair of lenses, spectacles, eyeglasses, or appurtenances thereto to the intended wearers thereof on written prescriptions from physicians or optometrists duly licensed to practice their profession, or duplication, replacements, reproductions or repetitions, must conform to the following minimum standards and tolerances:

PHYSICAL QUALITY AND APPEARANCE	TOLERANCE
Surface imperfections	No pits, scratches (other than hairline), grayness, or watermarks shall be acceptable.
Glass defects	No bubbles, striae and inclusions shall be acceptable.
Localized power errors	Waves found by visual inspection shall be passable if no deterioration in image quality is found when the localized area is examined with a standard lens measuring instrument.
Refractive powers	0.0 to 6.00 + or - 0.12. 6.25 to 12.00 2 percent of power. Above 12.00 + or - 0.25. Maximum cylinder power variation + or - 0.12.
Refractive power addition	+ or - 0.12D.
Cylinder Axis	0.12 to 0.37 + or - 3 degrees. 0.50 to 1.00 + or - 2 degrees. 1.12 on up + or - 1 degree.
Prism power and location of specified optical center	Vertical + or - 0.25 prism for each lens or a total of 0.50 prism imbalance. Horizontal + or - 0.25 prism for each lens or a total of 0.50 prism imbalance.
Segment size	+ or - 0.5 mm. Pair must be symmetrical upon visual inspection.
Segment location	As specified within + or - 0.5 mm.
Lens size:	
Rimless	+ or - 0.5 mm.
Bevel, for plastic frames	+ or - 0.5 mm.
Bevel, for metal frames	To fit standard specified frame.
	Lens shape must match. Edges must be smooth and straight and sharp edge must be removed.
Heat-treated and chemically-treated industrial safety eyewear	Tolerance for power, size, and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1-1972 and subsequent revisions.
Heat-treated and chemically-treated dress eyewear	Tolerance for power, size, and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1-1972 and subsequent revisions.

STATEMENT BY CARL E. BAUMANN, PRESIDENT, THE SOCIETY OF DISPENSING OPTICIANS, AT PUBLIC HEARING ON ASSEMBLY BILL 3264

May 22, 1975

Assembly Bill 3264 is consumer-oriented legislation in that it is designed to aid consumers in obtaining the lowest possible cost for eyewear. By permitting an ophthalmic dispenser to advertise prices the consumer ostensibly would be able to "shop" for price.

While the Society of Dispensing Opticians believes that the original prohibition against such advertising has served the public well, we can support A-3264 -- but only with the very important provision that the consumer be given one added measure of protection.

That is, that the bill be amended to provide that the eyewear so advertised meet certain minimum standards and tolerances established by the State Board of Examiners of Opthalmic Dispensers and Technicians.

While the purpose of A-3264 is laudable, we suggest that without the strict adherence to minimum standards and tolerances advertised prices could be misleading to the public-at-large, and consequently detrimental rather than beneficial. An accurate prescription for eyewear differs so greatly from person to person that an advertised price becomes virtually meaningless.

The existing prohibition against advertising prevents deceptive and misleading practices such as "bait and switch" advertising. The addition of our amendment will help protect the public against such practices.

We have already submitted to your Committee a proposed amendment which I shall read now for the record:

On Page 2, Section 1, add after line 25 the following language:

"It shall be unlawful for an ophthalmic dispenser or ophthalmic technician to provide eyeglasses which do not conform to any minimum standards and tolerances as established by the Board of Ophthalmic Dispensers and Technicians."

Gentlemen, The Society of Dispensing Opticians is prepared to assist your Committee in any way in helping to provide the public with eyewear that meets the highest professional standards at a reasonable cost.

Our proposed amendment will help accomplish that objective.

Thank you.

THE NEW JERSEY SOCIETY OF OPTOMETRY

c/o Dr. Richard Appel
Wall St. and Rt. 35
Eatontown, New Jersey 07724

TO: Honorable Byron M. Baer,
Chairman
Honorable Martin A. Herman,
Vice-Chairman
Honorable Mary Keating Croce
Honorable Arnold J. D'Ambrosa
Honorable Philip M. Keegan
Honorable Robert M. Ruane
Honorable Morton Salkind
Honorable Barbara A. Curran
Honorable C. Gus Rys

FROM: The New Jersey Society of Optometry

DATE: April 30, 1975

SUBJECT: Position of The New Jersey Society of Optometry on Assembly Bill A-3263

The following is the position of the New Jersey Society of Optometry on Assembly Bill A-3263, specifically Section U, Line 146 through 163.

The New Jersey Society of Optometry and all its members unanimously support the adoption of Section U for the following reasons and oppose its deletion by amendment:

1. Deletion of Section U would cause the lay employer, person, entity or organization such as a commercial optician to allot or control the time per patient that the employee optometrist would have rather than allowing the optometrist to allot time per patient in accordance with the individual patient's optometric needs and requirements.

2. The employment of an optometrist by a lay employer, person, entity or organization such as a commercial optician would allow that person or entity to dictate the fee schedule per patient visit for an optometric examination

This in turn would allow the lay person or organization by its control of the fee structure to utilize the fee or no fee examinations as a "steer-in" or leader for purposes of drawing the public in to sell them glasses or other ophthalmic materials.

3. The lay employer, person, entity or organization such as a commercial optometrist could dictate the utilizations of various lenses, frames and other ophthalmic materials which were surplus stock to the prescribing employee optometrist, through the utilization of bonuses to the optometrist for writing prescriptions in overstocked ophthalmic supplies or items that were hard to sell.

This type of economic interest and interference would cause the individual employee optometrist to lose his objectivity in prescribing the best optometric or ophthalmic material for the individual patient in accordance to the patient's own needs.

4. The employment of optometrists by lay employers, persons, entities or organizations such as a commercial optician would cause a loss of optometrist-patient relationships to such an extent that the individual optometrist would not be motivated to practice according to his highest ability as if he were employed in a practice under his own or a group name in the interest of protecting his own individual reputation and building a practice through good optometric care.

He would be more interested in protecting his job and the interest of the employer and the employer's sale of good and products. The individual optometrist in such a state of employment would not think of the patient's benefit as much as he would think of the patient as a prospective purchaser of his employer's merchandise.

Thus, the individual employed optometrist would become a tool of his employer in increasing sales rather than examining and advising the patient for his or her own benefit.

5. The employment of individual optometrists by lay employers, persons, entities or organizations would encourage the optometrist to prescribe glasses or a change of prescriptions in marginal cases and encourage the optometrist to write prescriptions by the utilization of bonuses, commissions or spifs.

In contrast, non-dispensing optometrists, such as the members of the New Jersey Society of Optometry have no economic interest whether they write new prescriptions or change the lens prescriptions of their patients. Their sole interest is only in making a complete and thorough examination of their patient and accurately diagnosing the state of their optometric health, regardless of whether or not such an examination would lead to a new prescription.

6. An optometrist who is employed by a lay employer, person, entity or organization may fail to refer to other medical authorities in the case of pathology before writing a prescription; in order to sell a pair of glasses.

Whereas, the non-dispensing optometrist in contrast, who is not employed by a lay employer, person, entity or organization such as a commercial optician, will always refer a patient who comes in for an examination with a small or even minute amount of pathology to an opthalmologist or other medical authorities before writing a prescription. A non-dispensing optometrist can do this as he has the patient's interest at heart rather than the desire to sell a pair of glasses.

Therefore, in view of the aforesaid reasons, The New Jersey Society of Optometry and all of its members urge that Section U of the Assembly Bill A-3263 and the amedment for its deletion be defeated.

DR. RICHARD S. APPEL
On behalf of the Members of
The New Jersey Society of
Optometry, who are as follows:

Dr. Richard S. Appel, P.A.
Wall St. & Rt. 35
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Dr. Russell Aronds
Route 22 Corner Mountain Ave.
Watchung, N.J. 07060

Dr. Burton C. Blaurock
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E. Brunswick, N.J. 08816

Dr. Jerome P. Feinstein
318A Brunswick Square Mall
Route 18
East Brunswick, N.J. 07716

Dr. Jeffrey I. Kaufman
390-A Market Street
Saddle Brook, N.J. 07662

Dr. Joseph Lehrman
52 A Wayne Hills Mall
Hamburg Turnpike
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East 71, Route 4
Paramus, N.J. 07672

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Dr. Martin Oxenhorn
K-Mart Plaza
Dover, N.J.

Dr. Paul R. Rosen
2456 A Route 22
Union, N.J. 07083

Dr. Frank S. Angelini
Route 38 & Lenola Rd.
R.D. #2
Moorestown, N.J. 08057

Dr. Aaron Abrams
Menlo Park Mall
Route #1
Edison, New Jersey 08817

Dr. Douglas Glazier
Route #46 West
Wayne, New Jersey

Dr. Arnold Shapiro
Laurel Square Shopping Center
Bricktown, New Jersey

Dr. Jerome Blumberg
1721 Morris Avenue
Union, New Jersey

Dr. Marvin Carns
245A Route #22
Union, New Jersey

Dr. Robert Epstein
East Brunswick, New Jersey

Dr. Ralph Vend
Hudson Shopping Plaza
Jersey City, New Jersey

Dr. Charles Zolot
Paramus, New Jersey

ESSEX COUNTY PHARMACEUTICAL SOCIETY

"D-DAY PHARMACY DIARY DIGEST"

A DIGEST OF

PROFESSIONAL PHARMACEUTICAL ACTIVITIES

PREPARED DURING THE PERIOD

MARCH 1, to MARCH 31, 1967

REPORT PRESENTED TO

DR. JAMES L. GODDARD

COMMISSIONER, UNITED STATES

FOOD AND DRUG ADMINISTRATION

COMMITTEE

GERALD R. SCALA, R.P. CHAIRMAN
NORMAN ABELS, R.P.
HAROLD BOBROS, R.P.
LEO DUBROW, R.P.
PASQUALE GERVASI, R.P.
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DAVID HARRIS, R.P.
MICHAEL IANNARONE, R.P.
GARY KENDLER, R.P.
ROBERT LUBMAN, R.P.
LEON REITER, R.P.

May 18, 1967

May 15, 1967

Dr. James L. Goddard, Commissioner
United States Food & Drug Administration
Department of Health, Education & Welfare
Arlington, Virginia

Dear Dr. Goddard:

On November 7, 1966, you were quoted in the AMERICAN DRUGGIST as saying you "would seriously consider the creation of a new class of non-legend drugs, restricted to sale by pharmacists, provided the need for such a move can be clearly demonstrated."

This comment stimulated the E.C.P.S. to initiate a program aimed at providing the proof you sought.

Immediately following this letter you will find a digest of public health activities performed by pharmacists which clearly demonstrates the need for a third class of Drugs. You will also find a sample of the mechanism used in compiling the necessary data to complete this report.

We are confident that this relatively small sample is overwhelming conclusive of the need for further protection of the general public in the distribution of medicinals. Such protection could be best provided by the establishment of a third class of drugs, such drugs to be sold without prescription only by pharmacists.

We hope that this presentation offers substantial support toward this goal. Your leadership in achieving this result is solicited by the Essex County Pharmaceutical Society.

Very truly yours,

Robert B. Lubman

Robert B. Lubman, President
Essex County Pharmaceutical Society

The vital role the pharmacist plays on the health tem has long been recognized. More recently this importance has been further emphasized when it was suggested that he accompany the doctor in government hospitals when the physician makes his rounds.

With the increasing use of more potent self-medication products and the expanding promotional activity of the "over the counter ethical medicinals", it is not surprising that the pharmacist's role in public safety is assuming greater importance.

His contribution to public health was recently demonstrated in a study conducted by the Essex County Pharmaceutical Society, a chapter of the New Jersey Pharmaceutical Association. This project titled "D-Day Pharmacy Diary Digest" was conducted through-out the month of March, 1967. It was initiated to offer documented proof that only the pharmacist by virtue of his education and training is equipped to offer the public the advice to prevent the misuse of improper use of over the counter medicinals.

One hundred five pharmacies (over 30%) in the county, participated in this program. The participating pharmacies, a heterogeneous group from the largest county in New Jersey, are located in the State's largest city, Newark, as well as in the many suburban cities and towns. The first one hundred diaries tabulated noted 888 entries. They were indicative of the many services as related to OTC medicinals, which could not be obtained except in a pharmacy. The statistical report shows how the pharmacist contributed to public safety when he acknowledged existing potential dangers by not dispensing and even discouraging

the use of over the counter medicinals, 263 times.

The pharmacist's professional judgment and experience was demonstrated six hundred and four times when he expressed that the patron was in need of advice by a medical expert or prescriber. Of these 604 referrals, it is documented that the advice was needed 407 times. Since many patrons who were referred for medical consultations were transients, and there was no way to follow through on these cases, how the remainder fared is not known.

While all entries in the diaries must be considered individually important, there are a number which merit mentioning.

> Book 2..patron #1..Patron requested a first aid cream by name. The pharmacist recommended immediate attention at the hospital as it was apparant there was blood-poisoning in the patron's arm. The hospital made the patient aware that he might have lost his arm if proper attention had not been given.
>
> Book 14..patron #3..Customer wanted citrate of magnesia and questioned if it was good for gas pains for her son. After questioning,..found patient had abdominal pains..suggested doctor. Patient operated for appendicitis.
>
> Book 18..patron 2..Patron requested a strong cathartic as CC pills were not strong enough. When questioned, patron had terrible cramps and no B.M. for 3 or 4 days. He said his abdomen was rigid. Patron was referred to M.D. Later confirmed by friend that the patient was hospitalized for appendectomy.
>
> Book 26..patron 1..Patient inquired concerning sore throad and glands. As throat was sore for several days and patient had lung surgery previously performed, it was imperative that the patient consult with his physician.
>
> Book 33..patron 1..Patron requested OTC diuretic preparation for burning urine. Pharmacist recommended a physician who diagnosed the case as gonorrhea.
>
> Book 53..patron 4..Patron requested a cough remedy for a lingering cough of 2 weeks. A physician was advised and the patient hospitalized with pneumonia.

Book 55..patron 5..Patron requested relief for back pain from shovelling snow. The physician was recommended who ordered bed-rest and traction.

Book 82..patron 3..Patron requested something for a raspy throat that he had for 2 months. The pharmacist suggested a physician at once. The advice was taken and the condition was finally diagnosed as a cancer of the larynx. Surgery was performed to remove the growth.

Detailed examination of the 888 entries reveal that the services offered by pharmacists are as varied as they are many. No categorical listing could document all the many and different requests by the patron and the assistance offered by the pharmacist. Neither do all the enclosed diaries represent the multitude of entries that might have been recorded. As stated in book number 10 under the last entry.."there are many instances where advice on various medications were given by the pharmacist. Intentions were to record them. But time and business problems often did not allow entries to be made. Details were soon forgotten."

NUMBER OF STORES IN ESSEX COUNTY---------- 325
NUMBER OF STORES REPORTING---------- 105
PERCENT OF STORES REPORT---------- 323
NUMBER OF ENTRIES IN FIRST HUNDRED DIARIES---------- 888*
NUMBER OF FEMALE PATRONS---------- 459*
PATRONS UNDER 21 YEARS OF AGE---------- 96*
PATRONS AGED 21-40---------- 422*
PATRONS OVER 41---------- 359**

SITUATIONS REQUIRING DIARY DIGEST ENTRIES

WHEN A PATRON IS INSTRUCTED TO CONSULT WITH A PHYSICIAN FOR ANY REASON----------604

WHEN A PATRON IS ADVISED NOT TO TAKE A PARTICULAR OTC MEDICINAL BECAUSE OF CARDIO-VASCULAR, DIABETES, THYROID 91

SUPPLYING INFORMATION ON DOSAGE AND USAGE---------- 62

SUPPLYING INFORMATION WHERE SIDE REACTIONS, SUCH AS DROWSINESS, WHICH MIGHT BE ESPECIALLY HARMFUL TO THE PATRON---------- 21

SUPPLYING INFORMATION WHERE IT IS APPARENT THE PATRON DOES NOT READ ENGLISH---------- 10

SUPPLYING INFORMATION WHERE IT IS APPARENT THE INDIVIDUAL DOES NOT UNDERSTAND THE WRITTEN LEGEND ON THE OTC LABEL 20

SUPPLYING INFORMATION WHEN AN OTC PREPARATION IS IN CONFLICT WITH PRESCRIPTIONS OR OTHER MEDICINALS TAKEN BY PATIENT----------25

MISCELLANEOUS---------- 52

MEDICAL PRACTIONERS KNOWN CONSULTED----------407

NUMBER TIMES PRESCRIPTIONS ORDERED BY MEDICAL PRESCRIBERS 257

NUMBER TIMES OVER THE COUNTER (OTC) SALES WERE MADE------225

NUMBER OF TIMES OTC SALES WERE REFUSED----------263

Note:It will be noted that the figures here quoted do not total out as in some cases there might have been a sale of OTC product and later a Rx ordered for the same entry.. It will be noted also that an entry might have been made for two or more reasons.

* Figures quoted represent the first 100 stores reporting

** Several entries were made without ages recorded.

CLASSIFICATION FOR ENTRIES*

ALLERGY---------- 5
ARTHRITIS---------- 1
ASTHMATIC---------- 7
ANALGESTICS---------- 34
ANAIGESICS EXTERNAL---------- 4
ANTIHISTAMINES (EXCLUSIVE OF COLD AND COUGH PREPARATIONS) 6
ANTISEPTICS---------- 6
ANTHELMINTICS---------- 3
ACCIDENTAL TAKING OF MEDICINALS OR OTHER PRODUCTS-------22
ATHELETES FOOT AND FUNGUS INFECTIONS---------- 10
BACH ACHES---------- 13
BOILS---------- 11
BURNS---------- 15
CHANGE OF LIFE---------- 2
COLD PREPARATIONS---------- 67
CONTRACEPTIVES---------- 2
CONTRAINDICATIONS (NOT LISTED IN COUGH & COLD PREPARATIONS 6
CORNS, CALLOUS, MOLES AND WARTS----------19
COUGH PREPARATIONS---------- 66
DENTAL, LIP AND ORAL---------- 18
DIURETICS----------16
DIZZINESS OR VERTIGO---------- 5
DRAWING PREPARATIONS AS SALVES AND WET DRESSINGS---------10
EAR AND EAR PREPARATIONS---------- 35
EYE AND EYE PREPARATIONS---------- 59
FEVER---------- 19
FIRST AID----------9
GASTRO INTESTINAL (INCLUDING DIARRHEA, CRAMPS & PAIN------ 47
HEMOSTATICS---------- 10
HIVES----------3
INFECTIONS AND IRRITATIONS----------37
LAXATIVES----------39
LOZENGES----------4
MENSTRUAL----------10
NERVES---------- 7
NOSE DROPS AND SPRAYS----------12
RASH, ITCH AND SKIN IRRITATIONS----------49
REDUCING---------- 2
SLEEPING---------- 7
SPRAINS, BRUISES AND BREAKS----------18
SORE THROATS----------20
SUPPOSITORIES AND RECTAL DISORDERS---------- 20
SWOLLEN GLANDS---------- 7
TONICS---------- 5
USE OF HOSPITAL SUPPLIES AND SUNDRIES---------- 9
USE, DOSAGE AND PREPARATIONS OF MEDICINALS----------19
VENEREAL----------3
VITAMINS----------16
PATRON MISTAKENLY REQUESTED AN ITEM AND WANTED SOMETHING ELSE---------- 25
MISC----------

* FIGURES QUOTED REPRESENT THE FIRST 100 PHARMACIES REPORTING

NUMBER ENTRIES

FIRST HUNDRED PHARMACIES REPORTING

NUMBER OF ENTRIES	NUMBER OF PHARMACIES
1	4
2	8
3	9
4	14
5	8
6	11
7	6
8	5
9	4
10	3
11	2
12	3
13	1
14	3
15	5
16	2
17	1
18	4
21	1
22	4
25	1
89	1

STATEMENT BY

ROBERT E. WUNDERLE

BEFORE THE

NEW JERSEY ASSEMBLY

COMMERCE, INDUSTRY, AND PROFESSIONS COMMITTEE

MAY 22, 1975

I am Robert E. Wunderle, Economist and Vice President of Public Affairs for the Pathmark Division of Supermarkets General Corporation. Pathmark is largest dispenser of prescriptions in the New York metropolitan area. We operate 82 pharmacies in supermarkets and free-standing drug stores.

Pathmark strongly urges the adoption of legislation which would permit the advertising of prescription prices as well as legislation that would require the posting of prescription prices in pharmacies. To that end we endorse A-3273 as proposed, and A-1228 with minor modification.

The basis for our support for these bills is quite simple --- the consumer's right to know.

Prescription drugs are perhaps the only commodity consumers now purchase without advance cost information. In an era when consumer advocates across the country are urging the maintenance of individual price marking on items as mundane as lima beans and peas, it is absurd that the cost of a vital element of human health and well being is veiled in secrecy prior to the purchase decision. Most tragic of all is that with the existing prohibition against advertising, the consumers who are the most dependent on prescription drugs, the elderly, and the long term maintenance prescription users, presently have no adequate means available of comparison

shopping. Complicating this travesty is the fact that many of those in greatest need of prescriptions live on fixed incomes and would therefore benefit the most if they could shop for, instead of settle for, prescription prices.

The regulatory prohibition against advertising prescription prices exacts an unconscionable toll on the American public.

Item 1. In July 1974, Pathmark introduced a senior citizens health plan (subsequently copied by many competitors) which, among other benefits, provided a 10% discount on prescription drugs for senior citizens. The existing regulation did not permit us to advertise the fact that senior citizens could get a 10% discount on prescriptions from Pathmark. Instead, we were relegated to using the saccharine phraseology of "we offer a discount to senior citizens, ask our pharmacist for details."

Interestingly, Section R.S. 45:14-12 (f) permits extending discounts to senior citizens but subsection (c) of that same regulation prohibits public disclosure of the amount of the discount.

Item 2. The New Jersey Medicaid Plan has critical financial problems and is considering a "co-payment" provision which would require medicaid recipitents to pay 50¢ for prescriptions that heretofore cost them nothing. Pathmark cannot advertise that a medicaid prescription filled at one of our pharmacies costs the state less than the amount permitted under the law. Pathmark charges medicaid our "current retail price" which, 75% of the time, is below the $1.85 professional fee plus the wholesale cost as permitted by medicaid regulations.

Item 3. Pathmark makes telephone disclosures of the price of various prescriptions, yet we are prohibited by the existing law from advertising that fact as well as listing the phone numbers to call. Not only are we

prohibited from advertising prices, but we are prohibited from encouraging consumers to shop for price.

Item 4. Every governmental, consumer group, or newspaper prescription price comparison ever published has shown astronomical differences in prescription prices between stores. The prohibition against advertising aids and abets consumers being victimized by the high prices rather than being able to make advantage of the low prices. In surveys conducted by local newspapers some of the price differentials found were as follows: 40 capsules (250 mg.) of Achromycin selling for $2.89 in Pathmark, sold for as much as $6.95 in another store--a 140% differential; 16 tablets (250 mg.) of Erythromycin, $2.29 in Pathmark versus $6.50 in another store--a 184% differential; and a prescription for 100 tablets (.25 mg.) of Lanoxin, $0.98 in Pathmark versus $2.95 in another store, a 201% differential.

Our observation on these discrepancies matches a recent finding by the U. S. Department of Justice:

> "Differentials such as these can only exist when they are unknown to potential consumers, for given a choice most consumers would refuse to pay 10 to 12 times the going price for a drug available elsewhere. The cost to the public for the lack of price competition is enormous."

We believe that the arguments against prescription advertising are specious and self-serving to those who are intent on unjustifiably maintaining higher margins and prices.

To argue that advertising prescription drugs will be a demand stimuli is to demean the intelligence of the American public as well as the integrity of the medical and pharmacy professions. First, why a

consumer would be motivated to buy Ampicillin or Insulin because they saw an advertisement stretches one's imagination. Second, a doctor's prescription is mandatory before the purchase of any prescription drug can be made.

To argue that advertising prescription drugs will encourage supermarkets and discount department stores to use prescription departments as loss leaders is to exhibit a gross misunderstanding of the margin structure in mass merchandise stores. Whereas an independent drug store may look at a 100% margin as standard and a 200% margin as exceptional, supermarkets look at a 20% margin as standard and a 35% margin as exceptional. Our prescription prices, as just demonstrated, as much as 201% lower than some competitors, still make our pharmacy departments self sustaining on a profit basis. We need only to maintain pharmacy margins, not decrease them to run profitable stores. Pathmark has not nor will it use its pharmacies as loss leaders.

To argue that prescription advertising will drive small pharmacies out of business is to deny the value of the convenience and service many provide. Many neighborhood pharmacies provide the convenience of location, late hours, and delivery, which they certainly have the legitimate right to charge for. Is it also not the right of consumers to know how much those services cost and then make an informed choice as to whether or not they want to pay for the service?

Pathmark's interest in the prescription advertising and prescription price posting is not new. On September 6, 1972 Pathmark filed lawsuits in New York, New Jersey, and Connecticut seeking rulings that these states' legal prohibitions against the advertising of prescription prices were invalid. The results of our efforts were (1) a "consent order"

in New Jersey to permit price posting, (2) a discontinuance in Connecticut after that state adopted a voluntary prescription posting statute, and (3) a termination of the litigation process since New York State adopted a mandatory prescription price posting statute. After incurring legal fees in excess of $125,000 Pathmark decided to not continue any of the lawsuits, and thus we stopped short of our ultimate goal.

In the deliberations over the consideration of permitting prescription price advertising and mandatory price posting, we do not have to rely on theoretical speculation on the probable effects of changes in the regulations. Currently, prescription advertising is permitted in 22 states including Delaware, Florida, Idaho, Iowa, Kentucky, Maryland, Missouri, Mississippi, Montana, Nevada, New Hampshire, New Mexico, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Washington, Wisconsin, Wyoming and the District of Columbia. The most recent state to permit prescription advertising has been Connecticut, where the new law went into effect on May 12, 1975.

Do not consumers in New Jersey have the same right to know the relative cost of prescriptions from various pharmacies? Your efforts can make the rights of New Jersey consumers a reality.

For the foregoing reasons we urge your favorable approval of A-3273 as proposed. In addition, we urge your approval of A-1228, amended however to stipulate a minimum size for the in-store sign without restricting its maximum size.

DRUG INTERACTIONS

DRUG	COMBINED WITH	INTERACTIONS
Aspirin or Salicylates	1 Coumadin (Warfarin) 2 Benemid or Col Benemid	Potentiates Anticoagulant action Inhibits Uricosuric action
Butazolidin Tandearil	1 Coumadin (Warfarin) 2 Orinase, Diabinese, Dymelor, Tolinase (Sulfonylureas) Displaces from Plasma	Potentiates Anticoagulant action Enhances Sulfonylurea effect
Tetracyclines, Terramycin & Rondomycin	Antacids & Milk MgO, $Al(OH)_3CaCO_3$ & Iron Salts	Inhibits tetracycline by chelation
Penicillin	1 Chloromycetin, tetracycline Antacids 2 Benemid	Inhibits Penicillin Enhances Penicillin
Griseofulvin	1 Anticoagulants 2 Phenobarbital	Inhibits Anticoagulant Inhibits Griseofulvin
Sulfonamides (not to be used in last trimester of pregnancy)	1 Anticoagulants 2 Sulfonylurea	Potentiates Anticoagulants Enhances hypoglycemic action
Coumadin (Warfarin)	1 Anabolic Steroids 2 Atromid S 3 Butazolidin & Tandearil 4 Choloxin 5 Ponstel 6 Quinidine & Quinine 7 Salicylates 8 Gantrisin 9 Tetracycline 10 Chloromycetin	Potentiates Anticoagulant Effect
Coumadin (Warfarin)	1 Antacids 2 Doriden 3 Griseofulvin 4 Placidyl 5 Barbiturates	Inhibits Anticoagulant Effect
Coumadin (Warfarin)	1 Alcohol 2 Chloral Hydrate	Response unpredictable
Sulfonylureas (Orinase, Diabinese, Tolinase, Dymelor) Insulin	1 Alcohol 2 Anabolic Steroids 3 Butazolidin, Tandearil 4 Inderal 5 Salicylates 6 Sulfonamides 7 Chloromycetin	Enhance Hypoglycemic Effect
	1 Choloxin 2 Corticosteroids	May increase blood glucose levels and necessitate increased dosage of hypoglycemic agent
Benemid Col Benemid	1 Penicillin 2 Sulfonamide 3 Indocin 4 Salicylates	1 Prolongs Penicillin 2 Potentiate Sulfonamide 3 Potentiate Indocin 4 Inhibits Uricosuric Action
Darvon	Norflex	Causes: tremors, confusion, anxiety
Tetracycline Rondomycin Lincocin Penicillin-G (Buffered)	Food	Inhibits Absorption of Antibiotics
Iron Therapy	Magnesium Trisilicate (Gelusil)	Decrease in Iron Absorption
Vibramycin Minocin	Food or Milk	Can give together
	MgO, $Al(OH)_3$ $CaCO_3$ & Iron Salts	Inhibits these tetracyclines by chelation

DRUG INTERACTIONS

DRUG	COMBINED WITH	INTERACTIONS
(MAO) Inhibitors (Monamine Oxidase Inhibitors) 1 Parnate 2 Marplan 3 Nardil 4 Eutonyl	Tricyclic Antidepressants 1 Elavil 2 Norpramin 3 Pertofrane 4 Tofranil (Imipramine) 5 Aventyl 6 Sinequan 7 Vivactil	Hyperpyretic Crisis or severe Convulsive Seizures may occur
	Sympathomimetics 1 Amphetamines 2 Ephedrine 3 Cheese (Aged) 4 Chianti Wine	Severe Headache Hypertensive Crisis Cardiac Arrhythmias Chest Pain Circulatory Insufficiency
	1 Narcotics 2 Alcohol	Potentiation of Alcohol & Narcotics
Allopurinol (Zyloprim)	Edecrin Thiazides	Antagonizes Uricosuria
Sulfonamides Tetracycline	Last trimester of Pregnancy	1 Damage to fetus 2 Causes discoloration of teeth and enamel hypoplasia
NegGram Declomycin Tetracyclines	Sunlight	Photosensitivity

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FOR THEIR AID IN THIS PROJECT—

A SPECIAL THANKS TO:

John E. Stambaugh, Jr., M.D., Ph.D.
144 North Drive
Haddonfield, New Jersey 08003

Daniel A. Hussar, Ph.D.
Associate Professor of Pharmacy
Phila. College of Pharmacy and Science
Philadelphia, Pa.

DRUG PRODUCT SELECTION AUTHORIZATION

_____

_____

_____

Dear Doctor

We would like your authorization on a new system whereby we could provide your patients and ours with a new method of dispensing prescription medications.

We are asking if you would approve of a plan whereby the following would hold true:

I, _____ a physician licensed to practice in the State of _____ hereby authorize Norman J. Kritz, a pharmacist, licensed in the State of New Jersey and all similarly licensed pharmacists associated with him in the practice of pharmacy at Cherry Hill Pharmacy, 2298 Chapel Ave., Cherry Hill, N.J., to dispense a drug product other than that I may prescribe by brand name, under the following conditions:

1. The drug product dispensed must be of the same established (generic) name as the drug product prescribed.
2. The drug product dispensed must be, in the professional opinion of the pharmacist, a high quality product from a reputable manufacturer.
3. In the event my prescription is handwritten and specifies a manufacturer's name in addition to the brand or established name of the drug product, the pharmacist will dispense only the drug product thus prescribed.
4. The drug selection authorized applies only to products of the following manufacturers–

1–Abbott	11–Parke Davis	21–Wyeth
2–Ayerst	12–Pfizer-Roerig	22–
3–Bristol	13–Robbins	23–
4–Ciba	14–Roche	24–
5–Endo	15–Rorer	25–
6–Geigy	16–Schering	26–
7–Lederle	17–Smith Kline & French	27–
8–Lilly	18–Squibb	28–
9–Marion	19–UpJohn	29–
10–Merck Sharpe & Dohme	20–U.S. Vitamin	30–

This authorization shall continue in effect until modified or terminated by me in writing.

_____
Name

_____
Address

_____

_____

_____
Date

SUBMITTED BY MR. NAWROCKI

I am Theodore Nawrocki, a community pharmacist from Union, New Jersey and a Trustee of the New Jersey Pharmaceutical Association.

Some of the comments I make -- come as a community pharmacist.

I would like to speak in opposition to the prescription price advertising and posting bills. A1228, A-3273 and A-736

The average pharmacist has been bending over backwards trying to provide prescription drugs to the public at a reasonable price. The record shows that the cost to the public for a tablet or a dose of medication today is almost exactly the same as it was ten years ago.* This is a record that we are proud of.

Over the last ten years we have seen some 7,000 community pharmacies forced out of business and those of us who have survived have seen our net profits on sales decline to the lowest point in history -- and yet we are in effect being told that there is not enough price competition at the retail level. This is almost unbelievable. My assessment of the problem is as follows:

The pharmaceutical manufacturers have been attacked, and rightly so I might add, for some 15 years now. This is, ever since the Kefaufer hearings. The public has read enough headlines to convince them that there are immense profits in prescription drugs and that many prescription drugs are grossly overpriced. There <u>are</u> immense profits being made and many prescription drugs <u>are</u> grossly overpriced. Only the pharmacist knows it is not he who is making the immense profits. These drugs are grossly overpriced before we add as much as a penny as our charge for dispensing them.

What has created our immediate problem is that the numerous prescription shoppings that show that the price of one certain prescription might vary between parmacies, has MISLED the public into thinking that it is the pharmacist

*Firestone Study: John M. Firestone, Ph.D. , Professor of Economics, the City College of the City University of New York

who is primarily responsible for the high prices they have to pay. Or perhaps, they view us as working hand and hand with the manufacturers and not in their interests. In any event our image has become tarnished and our credibility almost totally destroyed.

As a member of the Economic Interest Committee of our State Pharmacy Association I felt it was my duty to spend considerable time on this problem and that is why I am here today. I want to try to clear up some of the misconceptions about the pharmacists pricing practices and explain why there are legitimate reasons why the price that a pharmacist might charge for one certain prescription might vary. One such reason is the type of pricing system a pharmacist utilizes in his practice.

Prior to 1965 our associations were allowed to distribute prescription pricing schedules so that there would be uniform prices at the retail level. In 1965, the Anti-Trust Department of the U. S. Justice Department ruled that this was in violation of the Anti-Trust laws and stopped this practice. They felt that each pharmacist should adopt his own unique pricing system. Under these conditicns you could not expect that prices would be uniform now -- some ten years later. But the one factor that created some disparity in retail prices was the emergence of a totally new pricing system during this period. This is the fee-pricing system, whereby a flat charge is made on each and every prescription so that each and every prescription carried it's fair shareof providing prescription services to the community. Previously all pricing systems included a mark-up on the cost of the drug dispensed as the major part of the pricing system. Originally developed in Canada, it was recently reported that 95 per cent of the pharmacists in that country now price exclusively with a fee pricing system. As there was no real push to convince pharmacists in this country to adopt this pricing system, throughout the country only perhaps 30 per cent of the pharmacists utilize

this type of pricing. But more and more pharmacists are changing over each year from the traditional mark-up type pricing system to a fee pricing system.

Thus because all pharmacist do not use the same TYPE of pricing system, the price of one certain prescription might vary depending upon which type of system he might use. While prices of individual prescriptions will vary -- it is altogether possible that the average prescription charge might be identical at two different pharmacies.

In 1972 we recognized that we had to respond to the demand for more uniformity in prescription prices at the retail level. Recognizing also that fee pricing was more equitable to the public and the pharmacist -- we therefore recommended that each pharmacist seriously consider adopting such a pricing system. This action was followed by articles explaining the merits of fee pricing. Right now, I would say that perhaps 70 per cent of the pharmacists in this state now use a fee pricing system and therefore as a result prescription prices are much more uniform than in other states. Universal use of the same TYPE of pricing system would not lower prescription prices on an overall basis, but would reduce the extent of variations that occur when specific prescription prices are compared.

A second factor that influences the pharmacist charges are due to the services he gives. This includes not only convenience services, but also the professional services a pharmacist will implement in the dispensing process. Unfortunately, most of the public still views the prescription as a simple commodity. What they don't realize is that they are paying for the drug and pharmacist's charge for the services he provides in dispensing it. At times these services can be more important to the patron than the drug itself. Up until now we have seen surveys of prices charged without any indication of just what services a particular pharmacist provided. I have heard that the

Public Intereat Research Groups have recognized this problem and are planning on correlating services rendered with prices charged in the near future. This improvement in the shopping surveys is desperately needed so that they will be meaningful. Recently in the Buffalo, New York area, the Western New York Public Interest Research Group conducted a study of pharmacist services and the shocking thing they found was that only 2 out of 18 pharmacists even maintained a patient profile system. Certainly this should be cause for alarm since a pharmacist cannot utilize his knowledge of drugs to his fullest extent without such a system. I fully expect that within the next few years as the importance of the pharmacist services is recognized, that there will be criticism of those pharmacists who are not providing quality pharmaceutical services.....

A third factor that creates discrepancies in retail prices is caused by what the pharmacist has to pay for the drug dispensed. Due to the unusual pricing practices of the manufacturers -- one pharmacist may pay double for the same brand of drug than another pharmacist may pay. I doubt if this situation existsin any other industry. If drug manufacturers had to sell their products for prices that were related to their actual cost of manufacturing the item (as is the case in most other industries) the problem would not exist. I could go into more detail about this problem. I would just like to point out that in the case of antibiotic drugs, which seem to be the type of drug chosen for these prescription price surveys, the problem is especially acute. I have often wished that the drug chosen to be shopped was one where this factor did not influence the pharmacist's charges. Perhaps others have been shopped but the discrepancies were so small that they would not make interesting reading.

Another factor relating to the cost of the drug is that in violation of the Robinson-Patman act. Some manufacturers were found to be giving special

price concessions to some chains. The Portland Retail Druggist Association has obtained documentation on this practice and is in the process of instituting legal action to have it corrected. Both of our National Pharmacy Associations have pledged aid to this group.

Another factor that influences the pharmacist price is the brand of drug dispensed. What I am talking about here -- and these are the specific prescriptions that result in the huge differentials that are quoted so often -- are those prescriptions where the physician will prescribe by the chemical rather than the brand name.

Please remember that perhaps 90 per cent of the drugs the modern physician is using today are made by only one company -- or are made only by brand name companies -- and therefore no generic equivalent drug exists. So we are talking about a limited spectrum of the drug market. Now, when a pharmacist receives a prescription of this kind, he has the choice of which brand of drug to dispense. Some observers maintain that he should dispense the lowest price brand on the market -- and if he does not he is not properly serving the public. I have no love for the drug manufacturers, but as one trained for five years in how drugs work and what factors influence the THERAPEUTIC effect of that drug on the patient -- I do not always choose the least expensive brand of drug on these prescriptions. I have seen drugs that pass completely through the body without dissolving. I don't care how <u>cheap</u> that particular prescription was -- it was no <u>bargain</u>. Thousands of people were hospitalized recently in Canada because one brand of oral diabetic drug was not absorbed properly by the patients blood stream. People outside our profession claim we should use cheap generic drugs whenever possible. The truth of the matter is that until just this year we have no information to make a valid judgment as to whether or not one brand of drug was as good as another. We <u>had</u> to judge the drug by reputation of the company.

In fact, the American Pharmaceutical Association became so impatient with the lack of such information, that it decided to take matters into their own hands and has started publishing information about drugs so that the pharmacist can make an intelligent judgment between different brands of drugs. The first drug so covered was Digoxin. In the near future they plan to cover the oral diuretic drugs as these are expensive drugs and used extensively by many elderly people. Now once information concerning which brands are therapeutically equal is available to the pharmacist -- then and only then should pharmacists be critized for not using less expen sive brands in filling these prescriptions. We have not reached that point in time yet.

Even people in high places, who are supposedly well informed have been mistaken to some extent about the generic approach to lowering drug prices. Six months ago, Mr. Weinberger of Health, Education and Welfare, proposed that pharmacists be reimbursed for only the lowest cost nationally available drug in all governmental prescription programs. Just THIS WEEK he was informed by the Food and Drug Administration that this agency does not require manufacturers of generic drugs to submit the New Drug Applications or EVEN Abbreviated New Drug Applications before marketing their products. Agency officials admitted that a number of products may be on the market without F.D.A.'s knowledge. Further, another F.D.A. scientist revealed that at present the F.D.A. can only guarantee that drugs are chemically equivalent. At present, they have no mechanism to test drugs for bioavailability.

So, rather than criticize pharmacists for not dispensing the lowest cost drug on these prescriptions -- we should recognize that in truth he was more concerned about protecting the public's health.

The last factor that influences price comparisons -- and the one factor that makes me fear the spread of prescription price posting and prescription price advertising -- is the loss leader tactics of some pharmacy outlets. Although the popular impression is that there is no price competition in

prescription drugs -- the pharmacist knows better. The same type of loss leader tactics that exist in other lines exists in the prescription practice. Granted chains obtain some drugs for less than a community pharmacist may pay. However, there are some drug companies who do have a one price for all buyers. If you examine many of these prescription price surveys, you can see that some outlets are offering some of these drugs at exactly what they have to pay for them. If this is not competition, then I don't know what is. Also numerous studies of prescription department operating cost show that it costs any outlet a minimum of $1.00 to fill a prescription. Yet some discount prescription outlets will offer and post a price as low as $.60 as the complete cost of a prescription. Originally, prescription price posting was viewed as a factual means of informing the public about prescription prices. When we see prices posted, in the manner that they are, we know that these outlets are using the ability to post to deliberately mislead the public as to the true nature of their charges. We know this because we have found these outlets to charge as much as $3.50 over cost on a drug that is not posted. This is more than a full service community pharmacist will charge as his full dispensing fee.

In May of 1974, T. Donald Rucker, former chief of drug studies in the Social Security Administration, stressed this problem in a speech before the American Public Health Institute. He brought out that there was no way possible for the Board of Pharmacy to differentiate between factual posting of prices as the use of the ability to post as a promotional device.

If posting was done in a factual manner, that is if an outlet was forced to utilize a definite set fee or mark-up in his prescription pricing, and then forced to apply that same pricing system to each and every posted prescription price then perhaps we would not be so strongly against the spread of posting.

The final area I want to cover is the demand that the public has a right to know prescription prices before selecting a pharmacy. Therefore -- we are told we should post our prices. Anyone, anytime, can obtain the price of a prescription before it is filled. I doubt if any pharmacist would stay in practice for long if he did not extend that courtesy.

However, when it comes to posting, I don't really think it serves any purpose in view of the fact that the ability to post has been used to deliberately mislead the public. I want to add that it is almost impossible for a member of the public, or even a pharmacist for that matter, to accurately put a value on that part of the prescription's price that is represented as the pharmacist's charge for dispensing it. You would have to know the full extent of that particular pharmacists's knowledge about drugs, if, in fact, he was utilizing that knowledge to its fullest extent in the dispensing process in all the various forms of professional services he renders. Since so many variables are involved, it would be clearly impossible to make a determination with any real degree of accuracy. This, incidentally, is the reason that no profession allows price advertising as a means of building a clientele. Not because it's not classy -- but because it is simply too easy to mislead the public. Professionals recognize that what happens is that price competition encourages the members of the profession to cut corners in order to meet prices. This would be especially true in pharmacy as our net profits in this area of the country is down to something like 3% on sales. Any price competition cannot come out of profits but has to come out of services. With the potent drugs we are handling today it is vital to motivate pharmacists to move to upgrade the quality of their dispensing -- to do otherwise would be exposed shortly as being detrimental to the public's health. In fact, with the rising number of lawsuits directed against pharmacistsI think that there will be a demand for pharmacists to upgrade their services in the very near future. Those of us who fully realize that the pharmacist does more than

count out a few pills feel that THIS is what the public should be demanding from pharmacy. After all -- nothing is as important to a person as his health.

In addition both the prescription price advertizing and posting bills would inadvertently hurt those people, the elderely, who most desperately need help in paying for prescription drugs. Studies have shown that this group of people use on an average of 3 times the amount of medication that the average aged person uses.

Currently most of us have special program in effect whereby we offer these people special prices on medication. Some of us do not make a penny profit on these particular sales because of our pricing policies. In the event that the price competition in increased on the broad range of drugs-- as the advertizing and posting bills are intended to do-- then many of us will have no alternative but to discontinue these special senior citizen discount programs...

Therefore, on this one point alone, passage of these two bills should be delayed until such time as a Medicare prescription program is enacted into law. I make this point primarily because these people need a higher quality of pharmaceutical professional services than the average aged individual. Because their enzyme systems are less efficient, drugs are not eliminated from their body as fast as would be the case in a younger person. This results in an additional problem when trying to prevent an adverse drug reaction. Also this group requires a more extensive utilization review than other individuals. All too often we find them either not taking medication properly or when they do, forgetting that they took it and thereby taking more than the physician indicates they should.....

I would like to add one more thought:

T. Donald Rucker, former chief of drug studies in the Social Security Administration, stated in his recent address to the American Public Health service that too much attention has been given to attempting to reduce prices at the retail level. He felt that the main thrust of correction should come at correct abuses at the manufacturers level. He brought out that it is not unusual for a company to charge the pharmacist up to 15 times what it actually cost to manufacture package and ship a drug item. Not only should such a practice result in excessive profits, but also it allows the manufacturers to spend substantial sums of money on promotion. Dr. Milton Silverman and Dr. Philip Lee in their Book, "Pills, Profits and Politics" bring out that the effect of the pharmaceutical industry's hugh promotion is to cause an actual OVER-USE of prescription drugs. They estimate the cost to the public of the adverse drug reactions that thereby occur at some 4.5 Billion dollars a year. They also bring out that it is essential to motivate pharmacists to upgrade the quality of the professional services they implement in the dispensing process, as it can be shown that a pharmacist can prevent many of these reactions from occuring. Interestingly, Senator Gaylord Nelson, who has been investigating the pricing and profits of the pharmaceutical industry has introduced legislation to correct the monopoly pricing power of the manufacturers. He brought out that this is the only country in the world that allows a company to maintain complete price control over a product for 17 years after it is introduced. In every other country, other companies can produce a product (paying a royalty on their sales to the company that originally developed it) if they can bring it out at a lower cost. This legislation is in effect in Canada, and in spite of the fact that living costs are higher in that country than here, the pharmacist in Canada pays substantially less for many brand name drugs than the same company sell the same brand to the American Pharmacist. This legislation will create price competition to replace the marketing competition that exists now and is demonstrated by the over one billion

dollars a year spent on promotion prescription drugs.

The American Pharmaceutical Association has evidently come to realize that it is the pharmacists' duty to attempt to correct certain abuses of the pricing power of the pharmaceutical manufacturers. At the annual convention last month, the demand was made that the manufacturers discontinue the practice of selling certain drugs to hospitals and other outlets for much less than what the community pharmacist is charged. Evidence was brought out that while companies were almost continuously raising our cost - for a drug, they were welling the same drug, under the same brand name for up to 1/8 the price we had to pay.

Some figures might emphasize why efforts should be directed at the manufacturers level. The April i-sue of the First National City Bank of New York (Economy of the Nation) brought out that the net income of the drug manufacturers totaled some 1.73 BILLION dollars after taxes in 1974. This was up 13% from 1973. This represents a 21.4% annual return on these companies net worth. Interestingly, the only industry with a better showing, was the sugar industry with a 22.4% annual return in 1974. With the drcp in sugar prices, it seems evident that the drug companies will be number one in 1975. The Federal Income tax on these companies totaled some 1.3 BILLION dollars. In contrast, the net profits of all the 40,000 community pharmacies in the nation total about 320 Million dollars a year. This profit is equal to an 11% yearly return on invested capital - or some 40% less than the average return enjoyed by food and discount outlets.

Some have maintained that the increased use of generic drugs might substantially lower prescription drug prices. While savings can be made in this manner, much of the savings is an illusion as companies can respond to price competition in this limited area by simply raising the price of all the other items in their line. Only passage of Senator Gaylord Nelson's legislation will be truly effective in reducing the public's overall drug cost and in introducing price competition to replace the marketing competition that now exists at the manufacturer's level.

Let me give one example of the futility of directing efforts tc reduce prices

at the retail level:

No prescription drug we handle at the retail level is as competitive (at the retail level) as the oral contraceptive drugs. Ten years ago, we paid one dollar for a package containing a month's supply of the PILL. During the past 10 years the manufacturers found that they could cut the quantity of active ingredient and atill obtain effective results. Today, the PILL has 1/4 of the active ingredient that it had 10 years ago. Also during this period, the patent ran out on this active ingredient, Norethirone, and the price of this drug was reported to have dropped by some 75%. Today, you would think we are paying substantially less for this drug than we did 10 years ago...We are not!!!. Due to the unbelieveable pricing power of the pharmaceutical manufacturers wer are now paying DOUBLE for a month's supply of the PILL than we did 10 years ago. There is no doubt in my mind that it can be shown that we are in effect paying perhaps 25 times the actual complete manufacturing cost for some forms of this product.....

Increasing price competition at the retail level will not be the answer in reducing drug cost - at least not commensurate with better health care. The basic problem originates at the manufacturers level and that is where the main focus of correction must be made.

I want to make some comments on statements given by those who spoke in favor of the prescription advertising and posting bills:

Mr. Givens of the Federal Trade Commission made the statement that 300 million dollars could be saved if the advertising of prescription drugs was permitted. Since the total net profits after expenses of the 40,000 community pharmacists in this entire country is approximately the same amount, his charge has to be viewed as questionable, to say the least. Interestingly enough, the Portland Retail Druggists Association has pleaded with the FTC for the past 4 years to put an end to the price differential problem since it was in violation of the Robinson-Patman Act. To this day, the FTC claimed they do not have the resources to enforce this law. Thankfully, the Portland Group instituted action on their own and have just received a favorable decision from the 9th Circuit Court in regards to the price differential problem; in addition, it is instituting other actions to correct other abuses of the pharmaceutical manufacturers. The manufacturers are demanding that the case be taken to the supreme court. If the FTC was really so concerned about the price of drugs to the public, why have they been neglecting their duty to even enforce a law which is already on the books NOW ?

Mrs. Annich claims that the Board Of Pharmacy will prevent any pharmacist from dispensing in such a way that it would be detrimental to the public's health, and therefore, increased price competition whould be encouraged. The fallacy here is that no professional board can pass a regulation until such time as a certain professional service is used on an universal basis.

Even in New Jersey, where on a state-wide basis we are perhaps leading the nation in a movement to motivate pharmacists to prevent adverse drug reactions, at present the most the Board of Pharmacy can demand is that pharmacists ATTEMPT to prevent these reactions from occuring. Recognizing that with the shortage of physicians being what it is, the pharmacist is the only one who could prevent these reactions, we have embarked on a program in this state to educate the public the services of the pharmacist and how important these services are to them. This we hope will create a demand by the public for higher quality professional services from their pharmacist. Increased price competition at this critical time might jeopardize this entire program.

Robert Wunderle of Pathmark claims that their pharmacists are more professional because they do not do anything but fill prescriptions. The truth of the matter is that they are neglecting one of the pharmacist's most important functions— that of informing the public about the proper use of over-the counter medications.

Many adverse drug reactions are caused by these drugs, especially when they are taken concurrently with prescription medications. We fully recognize that the pharmacist's time costs us about 20¢ per minute, and therefore, this is a loss to the pharmacy. However, we feel it is our duty in protecting the public's health. Some chains do not even permit their pharmacists to advise the patron about the proper taking of their medication. They might not have a distinct policy in this regard, but it is well known that some chains do not put on additional pharmacists until such time as the present pharmacist is filling perhaps 200 prescriptions in an 8-hour shift. No pharmacist can possibly properly and thoroughly supervise that many persons' drug therapy, let alone check for possible drug-food and drug-drug reactions.

Mr. Wunderle also stated that their pharmacies carry complete stocks. If that were true, then why do we continuously get prescriptions that Pathmark and other chains cannot fill. We could reduce our costs considerably by stocking only fast-moving items. But when the public has to try perhaps 20 pharmacies to get a special item, I think you would have chaos in the health field. Also, when these chains "run out" of an item that they usually stock, they will direct the patron to go to a community pharmacy for it, rather than obtain it for them, eventhough it might be vitally important for the patient to continue on the therapy. We, on the other hand, in such a situation will try to secure that drug for the patron immediately for them so the patient's therapy is not interrupted. At times this is a very expensive proceedure. There are many services the community pharmacy performs that are not evident to the average member of the public. While the public would like lower drug prices, once customers realize what services they would have to do without, we have found that they then realize that they should not choose a pharmacist on the basis of the price he charges. Now, if the price advertising or posting bills are enacted, it is altogether possible that the pharmacists of New Jersey are going to spend the next 2 years telling the public about their services, explaining why prices vary, etc. What we have planned is for them to spend every available minute advising them about the proper taking of their medication, possible side-effects they might experience, etc. I think you can visualize which course of action would be more beneficial to the public. Since National Health Insurance is but a few years away, with prescription coverage included in the program, price legislation at the present time seems altogether unwise in view of the potential dangers.

Opposition to AS 3273 Richard Yale Miller R. P.

A. 1. I am chairman of the executive board of the Bergen County Pharmaceutical Society.
2. I am a member of the teaching faculty of Albany College of Pharmacy (Union University) and Rutgers University College of Pharmacy.
3. I write monthly articles for the N. J. Journal of Pharmacy and the Alabama Journal of Pharmacy. I have also authored articles for national pharmacy magazines.
4. I am the owner of a surgical pharmacy in Wyckoff, N. J.

B. I am opposed to AS 3273 on Rx price advertising because;

1. This bill will raise non-advertised prescription prices.
a. A pharmacy must make a profit to survive. By filling advertised prescriptions at or near cost the pharmacy must raise non-advertised prescription prices substantially to to meet expenses. Compounded prescriptions which are subsidized by other prescriptions will increase tremendously in price.
b. This is a big business bill, not a consumer bill. If prescriptions are filled at or near cost the only surviving pharmacys will be large chains who, after eliminating competition, will have no reason not to raise prices.
2. The consumer who desires service will also be short changed. With the elimination of the independent pharmacy, who will fill prescriptions in the middle of the night as I do - not the chain. Who will make deliverys to the senior citizen and the invalid as I do - not the chain. Who will be the backbone of the community, serving on various boards and organizations within the community as I do - not the chain pharmacist who usually does not live in the same municipality as the pharmacy. Four pharmacys have gone out of business in the Wyckoff area over the last few years - not because of incompetence - but because of pressure from chains that now sell many "hot" items at or near cost.

C. Members of the assembly, what do you consider a fair wage for me? I have an investment of over one hundred thousand dollars. My pharmacist wife and I work a sixty hour week and we net under twenty thousand dollars. Is this unreasonable?

D. Mrs Anich of the state consumer group mentions pharmacys that dispense ~~fxxxx~~ forty Achromycin capsules for $2.00. She uses this as a fair and equitable quote. Forty Achromycin cost the average pharmacy $1.84, giving a profit of 16¢. Assuming that a pharmacy fills ten prescriptions per hour (way above average) the pharmacy will gross 16¢ x 10 or $1.60 per hour. In-so-far as a pharmacist earns $8.00 per hour, is this a fair and justified quote. I think not.

(see over)

Conclusion:

If I am forced to give up services to my patients;
If I am forced to inventory inferior generic medications;
If I am forced to inventory automobile tires and antifreeze so that I might subsidize my prescription department;
If I am forced to do these unprofessional things - then I will no longer stay in retail pharmacy - or on the Board of Health, the Drug Abuse Council, the juvenile court, the Lions Club -

and I will let N. J. become the second class state in medical health that these well meaning consumer advocate people unintentially want.

STATEMENT BY THE NEW JERSEY STATE BOARD OF OPTOMETRISTS IN OPPOSITION TO ASSEMBLY BILL 3263 -- SPOKESMAN: DR. LEONARD BAKER, PRESIDENT

I AM DR. LEONARD BAKER, PRESIDENT OF THE NEW JERSEY STATE BOARD OF OPTOMETRISTS. I AM ACTIVELY ENGAGED IN THE PRACTICE OF OPTOMETRY IN BURLINGTON, NEW JERSEY FOR THE PAST 33 YEARS.

MY STATEMENT RELATIVE TO A-3263 REPRESENTS THE UNANIMOUS OPINION OF THE MEMBERS OF THE BOARD.

OUR BOARD HAS THE RESPONSIBILITY OF LICENSING OPTOMETRISTS BY EXAMINATION, MONITORING THE CONTINUING EDUCATION PROGRAM, ISSUING LICENSE RENEWALS, ACTING ON APPLICATIONS FOR BRANCH OFFICE LICENSES, HOLDING HEARINGS TO CONSIDER THE SUSPENSION OR REVOCATION OF LICENSES RELATIVE TO VIOLATIONS OF OUR LAW FOR SUCH INFRACTIONS AS FAILURE TO PERFORM THE MINIMUM EXAMINATION.

THE BOARD HAS ALWAYS BEEN IN THE FOREFRONT OF THE BATTLE FOR CONSUMER PROTECTION AND CONSUMER RIGHTS. OUR CONCERN HAS ALWAYS BEEN TO SEE THAT OUR LICENTIATES DELIVER THE HIGHEST QUALITY EYE CARE TO THE CONSUMER. THEREFORE, WE MUST VEHEMENTLY OPPOSE THIS ATTEMPT TO TURN THE CLOCK BACK IN NEW JERSEY 30 YEARS AND THUS ALLOW THE PUBLIC TO BE SUBJECTED TO INFERIOR EYE CARE UNDER THE SUBTERFUGE OF CONSUMER PROTECTION. A-3263 COMPLETELY EMASCULATES FROM OUR LAW VITAL SECTIONS THAT WOULD, IN A SHORT PERIOD OF TIME, DESTROY ALL OF THE PROTECTION GIVEN TO THE CONSUMER BY THE PRECEDING LEGISLATURES AND THE PAST FOUR GOVERNORS.

THE PROPONENTS OF THIS LEGISLATION MUST BE TOTALLY CONFUSED AS TO WHAT THE PROFESSION OF OPTOMETRY IS. THE OPTOMETRIST IS NOT A MERE MERCHANT OF EYE WEAR. HE HAS TODAY, IN ALMOST ALL INSTANCES, 4 YEARS OF PREPROFESSIONAL EDUCATION AND 4 YEARS OF GRADUATE STUDY EQUIVALENT TO THAT OF A PHYSICIAN AND A DENTIST. HE IS SPECIFICALLY EDUCATED TO EXAMINE, DIAGNOSE AND CARE FOR ALL CONDITIONS OF THE VISUAL SYSTEM. TODAY'S OPTOMETRIST, IN ADDITION TO PERFORMING COMPREHENSIVE EYE EXAMINATIONS AND REFRACTIONS, IS DEEPLY INVOLVED IN SUCH AREAS AS RESEARCH, ORTHOPTICS, VISION TRAINING, CONTACT LENSES, SUBNORMAL VISION AIDS, LEARNING DISABILITIES, PERCEPTUAL VISUAL PROBLEMS AND THE DIAGNOSIS OF OCULAR PATHOLOGY.

THE LEGISLATURES AND THE GOVERNORS OF THE PAST 25 YEARS HAVE RECOGNIZED THE IMPORTANCE OF THE PROFESSION OF OPTOMETRY. THE NEW JERSEY SUPREME COURT AND THE UNITED STATES SUPREME COURT HAVE SUPPORTED THIS PHILOSOPHY AND HAVE DECLARED OUR PRESENT LAW AS CONSTITUTIONAL AND IN THE BEST INTEREST OF THE PUBLIC.

GOVERNOR RICHARD J. HUGHES, NOW CHIEF JUSTICE OF OUR SUPREME COURT, IN SIGNING SENATE BILL 77 ON DECEMBER 23, 1963, ISSUED A STATEMENT THAT SUPPORTS OUR POSITION TODAY, AND HIS ASTUTE LEGAL MIND EXPRESSED IT MUCH MORE ADEQUATELY THAN I CAN.

"I have today signed Senate Bill 77, which prohibits the practice of optometry in mercantile establishments.

In this day and age, it is beyond dispute that the practice of optometry is no ordinary trade or occupation to be pursued in conformity with the procedures of the market place. Optometry is a learned profession, characterized by our Supreme Court as "an applied branch of the science of physiological optics, directed to the improvement of visual acuity through the correction of refractive errors." Abelson's Inc. v N.J. State Board of Optometrists, 5 N.J. 412, 418 (1950). Those privileged to practice this highly skilled calling not only serve the public interest, but also minister to one of the most vital of all physical needs, the care and treatment of the delicate and vulnerable eye which may in a very real sense be regarded as a lifeline to life itself.

Objectors to the enactment of Senate Bill 77 have maintained that a commercial setting cannot impair the high professional standards expected and required of the optometric profession. But it is common human experience that like begets like. The relationship between the optometrist and those whom he serves is, or should be, no less personal and dignified than the bond between attorney and client, or that between physician and patient. It has long been considered in the public interest to isolate those professions from the arena of mercantile activity, for obvious and salutary reasons. Is there any less reason to remove a profession which involves the scientific correction of human vision from that environment? No profession is practiced in a vacuum,

and it seems unrealistic to suppose that a profession practiced in a commercial milieu will not in time inevitably acquire a commercial flavor. The profession of optometry is too intimately involved in the health and well being of our citizens to risk the perils inherent in such commercialization. No erosion of professional standards has ever occurred overnight. This takes time and exposure to alien elements, which, though good in themselves, have no proper place in the formulation and maintenance of the criteria by which a learned and distinguished profession must live unless it is to die from a dearth of public confidence. It is never too soon to detect potential weaknesses and to erect appropriate safeguards. It can become too late.

As Governor of this State, and as a former judge of the Superior Court, I have always disapproved of the practice of placing unwarranted restrictions upon a lawful occupation by investing that occupation with a professional status which it does not in fact possess. Trinka Services v. State Board, etc. of N.J., 40 N.J. Super. 238 (Law. Div. 1956). But I am convinced that the practice of optometry entails a high professional dignity and sense of responsibility which transcends and repels any overtones of ordinary commercial endeavor. I am not unmindful that some will be inconvenienced by the enactment of Senate Bill 77. To these persons I say that this law reflects a measure of their professional stature and prestige. They should be proud, as I am, to be privileged to practice a profession which society has insisted upon elevating to the status of a public service. I am certain that the law which I have signed today must, in the long run, benefit every member of the optometric profession in the coin of renewed public confidence and esteem."

LET US NOT IN NEW JERSEY RETURN TO AN ERA WHERE OPTOMETRISTS WILL BE FOUND PRACTICING IN SUPERMARKETS AND DEPARTMENT STORES. THAT WILL FOSTER SITUATIONS WHERE THE SO-CALLED PROFESSIONAL HEALTH PRACTITIONER, I.E., THE OPTOMETRIST, WILL BE CONTROLLED SOLELY BY THE EMPLOYER, I.E., THE OPTICIAN OR THE CORPORATE STORE OWNER WHOSE SOLE CONCERN MUST BE THE SALE OF GLASSES. TODAY, A PAIR OF EYEGLASSES IS ONE OF THE END PRODUCTS OF A COMPREHENSIVE OPTOMETRIC EXAMINATION JUST AS A SET OF DENTURES, CAPS OR BRACES ARE THE END PRODUCTS OF DENTAL RESTORATION WORK. UNDER ASSEMBLY BILL 3263, THE SELLING OF EYEGLASSES BECOMES OF PARAMOUNT IMPORTANCE AND THE PERFORMANCE OF AN EYE EXAMINATION AN INCIDENTAL FUNCTION.

IN THE HALLMARK CASE OF WILLIAMSON VS. LEE OPTICAL, 348 U.S. 483 (1955), THE UNITED STATES SUPREME COURT SPECIFICALLY UPHELD OKLAHOMA REGULATIONS PROHIBITING THE ADVERTISING OF OPTOMETRIC SERVICES AND MATERIALS. THE COURT RECOGNIZED THE APPROPRIATENESS OF SUCH REGULATION WHERE PROFESSIONAL PRACTICES WERE INVOLVED. THE COURT STATED:

"IT SEEMS TO US THAT THIS REGULATION IS ON THE SAME CONSTITUTIONAL FOOTING AS THE DENIAL TO CORPORATIONS OF THE RIGHT TO PRACTICE DENTISTRY. SEMLER V. OREGON STATE EXAMINERS, SUPRA. (294 U.S. AT 611). IT IS AN ATTEMPT TO FREE THE PROFESSION, TO AS GREAT AN EXTENT AS POSSIBLE, FROM ALL TAINTS OF COMMERCIALISM. IT CERTAINLY MIGHT BE EASY FOR AN OPTOMETRIST WITH SPACE IN A RETAIL STORE TO BE MERELY A FRONT FOR THE RETAIL ESTABLISHMENT. IN ANY CASE, THE OPPORTUNITY FOR THAT NEXUS MAY BE TOO GREAT FOR SAFETY, IF THE EYE DOCTOR IS ALLOWED INSIDE THE RETAIL STORE. MOREOVER, IT MAY BE DEEMED IMPORTANT TO EFFECTIVE REGULATION THAT THE EYE DOCTOR BE

RESTRICTED TO GEOGRAPHICAL LOCATIONS THAT REDUCE THE TEMPTATIONS OF COMMERCIALISM. GEOGRAPHIC LOCATION MAY BE AN IMPORTANT CONSIDERATION IN LEGISLATIVE PROGRAM WHICH AIMS TO RAISE THE TREATMENT OF THE HUMAN EYE TO A STRICTLY PROFESSIONAL LEVEL. WE CANNOT SAY THAT THE REGULATION HAS NO RATIONAL RELATION TO THAT OBJECTIVE AND THEREFORE IS BEYOND CONSTITUTIONAL BOUNDS."

THUS, WHEN WE SPEAK OF HEALTH CARE PROFESSIONS, COMMERCIALISM IS NOT BENEFICIAL TO THE CONSUMER. ONE MUST BE WARY OF A PHYSICIAN OR DENTIST WHO PRACTICES IN THE MIDDLE OF A SUPERMARKET OR A DEPARTMENT STORE. IN THE COMMERCIAL SETTING, PROFESSIONAL JUDGEMENT IS REPLACED BY ECONOMIC CONSIDERATIONS. RESPONSIBILITY ON THE PART OF THE DOCTOR TO THE PATIENT DISAPPEARS. SUBSTITUTED IN ITS PLACE IS THE DOCTOR'S CONCERN FOR SPEED AND VOLUME AND A DESIRE TO PLEASE HIS LAY EMPLOYER WHO IS INTERESTED ONLY IN THE SALES OF EYE WEAR. THE COMMERCIAL SETTING CAN ONLY ENCOURAGE MISLEADING ADVERTISING AND BAIT-AND-SWITCH TACTICS, LONG A BANE OF THE CONSUMER AND SO DIFFICULT TO DETECT WHERE PROFESSIONAL SERVICES AND MATERIALS FOR VISION CARE ARE INVOLVED.

WE ARE NOW CONFRONTED WITH AN EFFORT TO RETURN TO COMMERCIALISM TO SATISFY THE DEMANDS OF THE CHAIN STORE OPERATIONS, THE HIGHWAY OPTICIANS AND THE OUT-AND-OUT COMMERCIALISTS, PRACTICALLY ALL OF WHOM ARE CONTROLLED BY OUT-OF-STATE INTERESTS AND HAVE NO CONCERN WITH THE HEALTH AND WELFARE OF THE PEOPLE OF NEW JERSEY. IF THE OPTOMETRISTS OF NEW JERSEY WERE TO REVERT BACK TO THE ERA OF COMMERCIALISM, THEY WILL FIND THAT THE ENTIRE FIBER OF THE PROFESSION WILL SOON BE DESTROYED. WHAT YOUNG PERSON, COLLEGE BOUND, WOULD

BE WILLING TO SPEND EIGHT YEARS OF PREPARATORY STUDY IN ORDER TO BECOME A DOCTOR OF OPTOMETRY, TO BE ULTIMATELY EMPLOYED BY A DEPARTMENT STORE?

THE NEW JERSEY STATE BOARD OF OPTOMETRISTS STRONGLY RESENTS THIS EFFORT TO EMASCULATE A PROUD HEALTH CARE PROFESSION IN THE GUISE OF CONSUMERISM. PASSAGE OF ASSEMBLY BILL 3263 WOULD NOT ONLY ERODE THE FABRIC OF THE PROFESSION OF OPTOMETRY, BUT WOULD WREAK HAVOC ON THE VISUAL WELFARE OF THE CITIZENS OF THIS STATE. WE ARE CERTAIN THAT ALL OF YOU WILL UNDERSTAND THAT THE TRUE INTEREST OF THE CONSUMER IS PROTECTED BY PRODUCING AN ATMOSPHERE WHERE THE PROFESSIONAL HEALTH CARE PRACTITIONER DERIVES HIS PATRONAGE BY REASON OF HIS SKILL, ABILITY AND REPUTATION, RATHER THAN ATTRACTING BY ADVERTISING.

I IMPLORE YOU, AS MEMBERS OF THIS IMPORTANT COMMITTEE, TO REJECT A-3263 AND ANY RELATED LEGISLATION.

THANK YOU FOR YOUR TIME, PATIENCE AND ATTENTION.

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STATEMENTS OF MARTIN E. JOHNSON, EXECUTIVE ASSISTANT
THE MEDICAL SOCIETY OF NEW JERSEY
SETON HALL UNIVERSITY SCHOOL OF LAW, NEWARK
MAY 22, 1975
ASSEMBLY COMMITTEE ON COMMERCE, INDUSTRY & PROFESSIONS

The Medical Society of New Jersey is opposed to A-3273 for the following reasons:

a. There is little or no evidence that advertising has led to a less costly product or service in any field be it automobiles, pharmaceuticals, appliances, etc. In fact, there is a significant feeling in the business world that advertising can often increase the cost of a given commodity or service to the consumer.

b. Advertising of prescription drugs is an extremely dangerous project to foster. The Medical Society of New Jersey has been trying to convince the public that there is not a "pill to cure everything", or "a pill for every occasion." This bill would create a carnival atmosphere in allowing prescription drugs to be advertised. Additionally the thought that Schedule II drugs -- that is those with the very real and dramatic potential for addiction and/or abuse would become the subject of advertising -- is absolutely horrifying.

Further, can you imagine the delight of the criminal element when it learns that "Z" Pharmacy is selling "amphetamines at a reduced price this week" and consequently presents a ready plum for the picking.

Gentlemen -- drug addiction and abuse is a real problem in New Jersey and this bill will, if anything, permit an added stimulus to it which we simply don't need..

Thank you for this opportunity to present our views.

STATMENTS OF MARTIN E. JOHNSON, EXECUTIVE ASSISTANT
THE MEDICAL SOCIETY OF NEW JERSEY
SETON HALL UNIVERSITY SCHOOL OF LAW, NEWARK
MAY 22, 1975
ASSEMBLY COMMITTEE ON COMMERCE, INDUSTRY & PROFESSIONS

The Medical Society of New Jersey is opposed to A-3263 for the following reasons:

a. Optometry has been declared by the Legislature to be a "profession". It does, in fact, render a valued and necessary health care service. Health care services should be rendered in a dignified and respectful atmosphere and with a professional "aura". People seeking these services should be treated as patients needing care, rather than customers buying shoes, cars, appliances, etc. The permission of advertising and location of optometry offices in retail settings will depersonalize the services in question and deprofessionalize optometry.

b. There are no assurances that advertising of services and products will produce lower costs or that if lower costs are really effected that they will, indeed, be passed on to patients. You should also realize that since advertising is not currently engaged in, it is not a cost factor Once it becomes one, it will inevitably increase the cost of practice. Further, the individual practitioner or small group will be at a distinct disadvantage and unable to compete with the advertising power of large groups or chain organizations.

c. If, in fact, optometry is to be permitted to advertise then all professions including law and medicine should also be so permitted, for if the premise is sound, it should be universally applied. This bill permits optometrists to advertise, but does not repeal the

prohibitions against advertising that exist in the other professions, especially the health care professions.

It is our considered opinion that the utilization of advertising techniques in the practice of the professions in general and the health professions, in particular, will only produce higher costs for the public.

Thank you for this opportunity to present our views.

STATEMENT

OF

HON. STANLEY C. VAN NESS,
PUBLIC ADVOCATE

FOR THE HEARING OF THE ASSEMBLY COMMITTEE

ON COMMERCE, INDUSTRY AND PROFESSIONS, MAY 22nd, 1975.

Seton Hall Law School
Newark, New Jersey

I would like to offer this statement in favor of A-736 and A-3273, whose intent is to eliminate the present statutory ban on the advertising of prescription drug prices, and A-1228, which will require in-store posting of prices for the 100 most commonly used prescription drugs. Prior to the announcement of these proposed bills, staff in my Department had been investigating for some time the possibility of legal action against the statutory ban. As a result we had arrived at the conclusion that the prohibition against the advertising of prescription drug prices should be legally challenged. Although my remarks will focus mostly on legal commentary on the issue, let me underscore our conclusion that a fair weighing of all considerations convincingly compels the conclusion that abolishing the ban is proper. While we make no specific comments on the other two bills before you, it is apparent that my remarks will have some application to their purposes as well.

We begin with a recognition that the ban on advertising results in a situation where the price of the same prescription drug will vary considerably from store to store, with consumers effectively unable to monitor the differences. We are aware of studies in at least a dozen states, at least two in New Jersey, which uniformly reveal this. While these study results may vary insofar as the highest degree of variance shown, they have revealed variances of from 250% to 1200% in some instances and 50% or more in general. What these studies of the most commonly used drugs uniformly show is that many consumers--unable to find out in advance the prices charged at particular pharmacies--will frequently pay

much more than they might have had they been able to exercise price choice. In 1972 the U.S. Justice Department concluded that the main result of the bans on price advertising was a reduction in incentive for price competition, with resulting higher cost to consumers. According to a report in the New York Times, last year the staff of the Federal Trade Commission recommended invalidation of such laws and regulations prohibiting advertising, alleging that the nationwide savings to consumers would be "staggering."

Even if it is impossible to precisely project the potential savings to consumers in dollar amounts, it can hardly be doubted that there would be considerable movement by consumers toward lower price purchases if they were aware of them. Certainly people on low and fixed incomes, particularly the elderly, who tend to utilize prescription drugs disproportionately compared to other population groups, have a critical interest in seeking the lowest possible prices. It would seem to be a foolish public policy that would discourage consumers' abilities to do that. Thus even apart from the issue of reduced expenditures by consumers in general, there is an important need and right of individuals to be sufficiently informed so as to effectively exercise choice. This right is important to the public in general, but particularly crucial to the poor and elderly who--in addition to budgeting problems--have even less mobility to go from pharmacy to pharmacy to compare drug prices. Although other considerations than price alone may affect the consumer's choice, the choice should be his.

The most recent published Court decision concerning the ban on this price advertising, decided by the federal courts last year, underscored this right to

be effectively informed. This case, Virginia Citizens Consumer Council, Inc. vs. State Board of Pharmacy,* held that the consumers' right to be informed about the prices of prescription drugs was protected by the First Amendment, and that the ban on such advertising impermissibly infringed on this right. Observing that wide disparities existed in the prices for the same drugs, the Court stressed that the obtaining of drugs at the lowest possible price was important to many people, and added:

> "Why the customer is refused this knowledge is not convincingly explained by the State Board of Pharmacy and its members. Enforcement of the ban gives no succor to the public health; on the contrary, access by the infirm or poor to the price of prescription drugs would be for their good."**

This case has been accepted for argument on appeal by the United States Supreme Court this coming term. We fully support its conclusion, and commend its reasoning to you. The same holding was reached only last week in the Federal Court in California.***

Over the last few years, the highest courts in Florida, Pennsylvania and Maryland**** have invalidated bans on prescription drug advertising as unreasonable and not rationally related to the accomplishment of valid goals. Finding as fact that there were wide disparities in the prices of the same drug from pharmacy to pharmacy, these Courts like the Federal court, stressed the detrimental affects

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*373 F. Supp. 683 (F.D. Va. 1974)

**Id., at p. 687

***Terry v. California State Board of Pharmacy, U.S. Dist. Ct., N.D. Calif., No. C-74-1091 RFP (SJ), 5/12/75.

****See Florida Board of Pharmacy v. Webb's City, Inc., 219 So.2d 681 (1969); Pennsylvania State Board of Pharmacy v. Pastor, 272 A.2d 487 (1971); Maryland Board of Pharmacy v. Sav-A-Lot, Inc., 311 A.2d 242 (1973).

of the advertising bans on consumers. Thus the Pensylvania Court stated:

> "Lack of information on prices, occasioned in part by the instant prohibition, results in consumers having little idea as to the proper prices for prescription drugs, thus running a substantial chance of paying more for medicines than is necessary."*

And the Maryland Supreme Court further pointed out:

> "The ban on advertising prescription drug prices imposes a burden on senior citizens because they are unable to conduct any investigation, such as by reading advertisements, to learn the available prices for drugs. Many of these persons have a great need for maintenance-type drugs. Apart from what the record discloses, it is clear that these conditions also apply to those who have modest or low incomes...It follows that it would be in the best interests of the public to be informed of prescription drug prices to enable purchasing at the lowest available prices."**

Thus the clear weight of judicial authority favors overturning such bans. Some nine years ago, a trial judge in New Jersey upheld our own statutory ban in the case of Supermarkets General Corp. v. Sills,*** which was not appealed to the upper courts. Not only did the judge in that case agree that the rationales put forth to jutisfy the ban were dubious, but the more recent cases mentioned above have all conclusively rejected those same arguments. While we feel that our appellate courts would reach a decision contrary to Sills in a challenge to the advertising ban brought today, we believe that it should not be necessary to have to resort to the courts to remove this ban. It is something that the Legislature can and, we believe, should do.

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*Pastor, at p. 494.

**Sav-A-Lot, Inc., at p. 252.

***93 N.J. Super. 326 (Ch. Div. 1966)

While we do, as noted, fully agree that the rationales offered to support the ban are inadequate, we would stress that they do not address what we consider the most important consideration in evaluating the bans. That is, that the public interest clear demands, in our opinion, the consumers' right to be adequately informed as to drug prices, so that he may meaningfully exercise choice as to how he will allocate his resources for his vital needs. In view of the grave importance of this right to be informed--so particularly important to the elderly and poor--, and in view of the strong potential for general savings to consumers, there would have to be extremely persuasive justifications for retaining this ban. The weight of judicial authority, while now clearly rejecting the bans on drug price advertising, have in fact rejected those arguments most commonly offered by its supporters as justifying it. It is appropriate to briefly mention those arguments.

First, it is argued that the ban promotes professionalism by preventing unseemly competition that would be demeaning to the pharmacy profession. While we certainly agree that pharmacy is a profession, as attested to by its rigorous educational requirements, it is one which has many purely retail and commercial aspectsin addition to service ones. Price advertising relates merely to a retail function,* and serves as a tool to educate the public. There are many other rules and regulations which support the professional service aspects of pharmacy practice.

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*This point is underscored by the Maryland Supreme Court, in the Sav-A-Lot case earlier referred to, at pp. 248-49; and by the 1971 Policy Statement of the U. S. Justice Dept. regarding state restrictions on the advertising of retail prescription drugs. Indeed, it is widely recognized that at best only 10% of prescriptions are compounded by pharmacists.

A second common argument is that advertising prices would encourage increased use and abuse of drugs. More recently a few proponents have further suggested that price advertising would open the door to extensive mass-media advertising, which similarly would encourage increased use and abuse. While the effects of mass-media advertising are conjectural, suffice it to say that this is a straw issue; the instant proposal deals only with price advertising, and does not authorize any other kind. And it is hard to imagine how advertising the prices of drugs would stimulate use of those drugs. All the recent decisions have readily dismissed this contention. Price becomes relevant only after a physician has prescribed a drug for the consumer.

A somewhat kindred argument is the suggestion that physicians might prescribe larger-than-necessary quantities of drugs so as to enable their patients to make use of quantity discounts. This contention, like the last one, presupposes unprofessional and unethical conduct on the part of physicians, a consideration we can give no weight to.

A fourth common argument suggests that the need of pharmacists to purchase in bulk will lead to unnecessary stockpiling of drugs on their shelves, and, in turn, cause risks of drug deterioration. To the extent that this is suggested as a threat to the public health, it seems to be an insult to the professionalism of pharmacists themselves. Furthermore, it is a problem better dealt with by rules affecting adulteration and contamination.

Finally, it is argued that eliminating the ban will encourage "shopping around" by consumers and that this will undercut the effectiveness of pharmacists monitoring their patients. While the recent court decisions have found such monitoring to be infrequent and ineffective, New Jersey now employs a mandatory patient "profile" system. Nonetheless, the importance of this system is only marginal.

The primary monitoring of the patient is done by the physician, and there are many respects in which the communication between the customer and pharmacist on any particular visit will be more helpful to the consumer than reference to a profile maintained in a single store.* Besides, it is not clear how much the advertising ban will increase consumer use of multiple pharmacies. Consumers already may use different pharmacies at present, purely by such chance considerations as whether they are at work, or home, or near the doctor's office, or need a delivery or some other service when they fill the prescription. The proposed legislation before us would replace chance and lack of information with rational choice, and would seem to far outweigh any benefits of the monitoring system.

I would like to end my remarks with two additional comments on the bills. First, it seems that between A-736 and A-3273, the latter may be less satisfactory by retaining bans on including phrases like "cut-rate" and "discount" in advertising. While such a restriction may cause unintended problems with some pharmacies which have existing store names or slogans that may be in conflict, we would also point out that the federal court decision in California earlier alluded to invalidated asimilar advertising prohibition as unconstitutional. Second, our final comment relates to A-1228, which would in effect require pharmacies to post the prices of most commonly used prescription drugs, on premises. While we feel that this is a sound step forward, we do not feel it can be a substitute for the removal of the advertising ban. Posting would still require visits to various pharmacies in order to make price comparisons and we have noted that this is something which many people, particularly the poor and elderly, cannot do.

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*The Pennsylvania Supreme Court noted that:

". . . If the Legislature was in fact concerned about the prescribing of antagonistic drugs, it would have chosen a route more direct than simply prohibiting the advertising of their prices." Pennsylvania State Board of Pharmacy v. Pastor, 272 A.2d 487, 493 (1971).

THE REMARKS IN THIS TESTIMONY REPRESENT ONLY THE VIEWS OF A MEMBER OF THE FEDERAL TRADE COMMISSION STAFF. THEY ARE NOT INTENDED TO BE, AND SHOULD NOT BE CONSTRUED AS, REPRESENTATIVE OF AN OFFICIAL FEDERAL TRADE COMMISSION POLICY

STATEMENT OF

B. SHARON BYRD
OFFICE OF POLICY PLANNING AND EVALUATION
FEDERAL TRADE COMMISSION

BEFORE THE

OKLAHOMA SENATE PUBLIC AND MENTAL HEALTH COMMITTEE

Oklahoma City, Oklahoma

April 28, 1975

THE REMARKS IN THIS TESTIMONY REPRESENT ONLY THE VIEWS OF A MEMBER OF THE FEDERAL TRADE COMMISSION STAFF. THEY ARE NOT INTENDED TO BE, AND SHOULD NOT BE CONSTRUED AS, REPRESENTATIVE OF AN OFFICIAL FEDERAL TRADE COMMISSION POLICY

Mr. Chairman, I am happy to be here today to testify concerning Senate Bill 261. This bill, introduced by Senator Stipe and others, would permit the advertising of eyeglasses in the State of Oklahoma.

As I am sure you all are aware, the impact of government regulation is being reassessed today. Regulatory schemes, which seemed like a good idea in decades past, are being re-examined in light of the economic problems which currently characterizes our economy. I can think of nothing more appropriate at this time than the effort by state legislatures to review their own state's regulatory structure in an effort to fight inflation and save their consumers money. It seems to me that that is exactly what these hearings today are all about.

In the Office of Policy Planning at the Federal Trade Commission we make an effort to review FTC programs in light of their potential benefit to consumers. Since a properly functioning free market system most efficiently supplies consumers with what they want, we try to insure that the

market functions properly--with multiple suppliers competing in markets, free of artificial restraints, supplying information of appropriate quantity and quality. After all, fostering competition to the benefit of consumers is what the Federal Trade Commission is all about. With this goal in mind, it is, therefore, imperative to consider the following questions:

1) Has the market failed in some respect?

2) If the market has failed, what are the reasons for the failure?

3) What can be done to correct the failure and at what cost?

4) What are the approximate dollar benefits to consumers of correcting the market failure?

I shall attempt to consider these questions throughout my testimony today.

Senate Bill 261 would permit the advertising of eyeglasses, contact lenses and related merchandise. It would prohibit false or misleading advertisements and would also prohibit the advertising of eye examinations or treatment.

Is Senate Bill 261 addressed to a failure in the market? It certainly will make more information available to consumers. The more information a consumer has, the more likely he will be able to choose among competing products to satisfy his wants.

When I buy a pair of eyeglasses I am interested in many different factors, such as the style of the frames, the color and material of the lens, the distance I must travel to purchase them and also the price. I might be willing to pay somewhat more for the same pair of eyeglasses if I only have to walk across the street to make the purchase. If I want to purchase several pair, I might be willing to travel a greater distance to save myself some money. I will make comparisons between these various factors to the point at which the alternative use of my time is more valuable to me than the increased satisfaction I gain from finding the "right" pair of glasses. Stated differently, I will incur various costs of search to the point at which they outweigh the benefits I derive from the search.

Advertising restrictions on the price of eyeglasses raise search costs to consumers. If consumers cannot find information on price by merely reading advertisements, they must make telephone calls or trips to the seller of eyeglasses. If they want to compare prices they must make

several telephone calls or several trips. The more information is restricted the more effort they must engage in to obtain that information. Their cost of search for the "right" pair of eyeglasses increases. Senate Bill 261, by permitting price advertising will lower the cost of search to Oklahoma consumers of eyeglasses. It will increase the information available to consumers and therefore facilitate their decisions in the market.

Increased search costs, however, are only one result of restrictions on price advertising of prescription eyeglasses. Another is overall higher prices. If information on price is more costly to come by, fewer consumers will be willing to incur this cost. Some consumers may not even be aware of price differences among sellers.

The incentive for sellers to lower their prices and attract more customers is decreased. They cannot easily tell consumers of their relatively low prices since they cannot advertise them. In fact, if price information is costly, many sellers of eyeglasses can charge higher than competitive prices knowing that many consumers will not know where to look for low-priced sellers. One would expect, then, to find generally higher prices for eyeglasses in states with price advertising restrictions than in those states without such restrictions.

Professor Lee Benham, who is also here today, has done studies on the effect of advertising restrictions on the price of eyeglasses. */ In his first study, he found that prices are 25% to 100% higher in states with advertising restrictions than in those states without such restrictions.

One need only look to the neighboring state of Texas to see what a little price competition can do to lower prices. A well-known optical chain there sells contact lenses for $69.50. It is my understanding that those lenses cost approximately 26¢ a pair for the raw materials, about one hour's labor for their production, and a certain amount of time for their fitting. In Oklahoma, contact lenses retail for about $150.00.

Some might argue that the higher prices in states, such as as Oklahoma, which restrict price advertising, reflect higher quality care. Sure, they might say, average prices are higher in states like Oklahoma because a larger proportion of Oklahomans receive eye care from professionals whose time is worth more money. Professor Benham in his second study also considered this possibility. He compared the price of eyeglasses between states restricting and not restricting advertising by source

*/ Benham, Lee, The Effect of Advertising on the Price of Eyeglasses, 15 J. Of Law and Econ. 337 (1972); and L. Benham and A. Benham, Price Structure and Professional Control of Information, March 1973, working draft.

of care. He found that for each source, ophthalmologists, optometrists and chain outlets, prices were lower in states permitting the advertising of eyeglasses. Stated differently, he found that high quality professional work is also cheaper in states such as Texas.

Certainly, some consumers will prefer to pay higher prices and receive perhaps more "professional" care. Some consumers undoubtedly derive benefit from plush waiting rooms or highly individualized service, and will be willing to pay for it. Some consumers buy Cadillacs too. But others buy Volkswagens. We do not restrict production of automobiles to Cadillacs. Should we restrict eyeglasses sales to the Cadillac sellers of eyeglasses? I suggest that price advertising restrictions, which prevent low priced sellers from telling consumers what they have to offer, operate with a similar effect.

So far I've stated that prices of eyeglasses are higher in states restricting advertising. What exactly does that mean in terms of loss to the consumers in Oklahoma? I have done some rough estimates. Oklahomans spend approximately 14.5 million dollars yearly on eyeglasses. */ If prices are higher than the competitive level because of advertising restrictions,

*/ For an explanation of all calculations and sources, see Appendix.

consumers lose in two ways. One loss, the redistributive loss, represents the difference in what consumers are paying for eyeglasses and what they would be paying if prices were at the competitive level. The other loss, a dead-weight loss, represents the loss sustained by those consumers who do not purchase eyeglasses at present prices but would purchase them at the competitive price. Let us assume, for the moment, that Professor Benham's study is correct, and consider his lowest estimate of the effect on price from restrictions on advertising. If prices are in fact 25% higher in Oklahoma, Oklahomans lose over three million dollars yearly because of advertising restrictions. What does this loss mean if it continues over a ten-year period? We all know that a dollar in ten years is not worth a dollar today. Therefore, we must discount the value of this loss by an estimated inflation rate. At a 5% discount rate, the present value of a three million dollar loss continued over a ten-year period is over 23 million dollars.

Perhaps Professor Benham's 25% figure is not exact for the State of Oklahoma. Perhaps Oklahomans lose only one million dollars yearly from advertising restrictions, or perhaps five million. In any event, and for whatever figures you might want to consider, advertising restrictions raise prices. The question is whether Oklahomans should be

paying these higher prices. Some might say that that's the cost of maintaining "professionalism" in the eyeglass industry. I view it more as the cost of restraints on the free flow of information in the market. However you choose to view it, the question is whether you want to pay it. That is for the determination of the Oklahoma legislature. I would urge you to support Senate Bill 261.

Appendix

As of 1968 there were 247 active optometrists, 97 active ophthalmologists and 130 active opticians in the State of Oklahoma. */ The mean annual gross income of optometrists is approximately $50,000, of opthalmologists $70,000 and of opticians $36,000. **/ These figures imply that Oklahomans spent approximately $12,350,000 on optometric services, $6,790,000 on ophthalmologic services and $4,680,000 on opticianry services in 1968. These amounts include all services and sales. Assuming that 3/4 of optometric, 1/2 of 22% of ophthalmologic and all of opticianry sales were for eyeglasses and related merchandise ***/, Oklahomans spent $9,262,500 on eyeglasses from optometrists, $746,900 from ophthalmologists, and $4,680,000 from opticians for a total of $14,689,400.

If prices were 25% higher than they would have been without advertising restrictions, we can use the following formula to determine redistributive loss from advertising restrictions:

*/ Optometrists Employed in Health Services, United States - 1968, U.S. Department of Health, Education and Welfare, (HSM) 73-1803 (1973); Ophthalmology Manpower, A General Profile, United States - 1968, U. S. Department of Health, Education and Welfare (HSM) 73-1800 (1972) and Opticians Employed in Health Services, United States - 1969, U.S. Department of Health, Education and Welfare, (HSM) 72-1052.

**/ For optometrists see, Chipman, F. AOA 1969 Economic Survey, Part IV, Journal of the American Optometric Association, 5.41 #6, June 1970, p. 551; for ophthalmologists see, Owens, A. Solo vs. Partnership: A New Economic Comparison, Med. Econ., March 15, 1971, p. 86. I had no figures for opticians but estimated that their income would bear somewhat the same relationship to optometrists income as optometrists income bears to ophthalmologists income.

***/ Optometrists both fill their own prescriptions and also some of those from ophthalmologists, hence 3/4; 22% of ophthalmologists sell eyeglasses (see, Ophthalmology Manpower: Characteristics of Clinical Practice, United States, 1968, Dept. of Health, Education and Welfare (HSM) 73-1802); and 1/2 of the sales of the 22% are probably from the sale of eyeglasses.

$14,689,400 = X + .25 X = total spent on eyeglasses in Okla.

-$11,751,520 = X = amount that would have been spent without advertising restrictions

$ 2,937,880 = redistributive loss to Oklahomans from advertising restrictions.

The dead-weight loss to the Oklahoma economy from these restrictions is derived from the following formula:

$$W = 1/2 \cdot R \cdot e \cdot (PD)^2$$ */

The elasticity of demand was estimated by Benham in his second article to be -.58. Using our data we get:

$$W = 1/2 \cdot \$14,689,400 \cdot .58 \cdot (.25)^2$$
$$W = \$266,245$$

Combining redistributive and dead-weight loss we get $3,204,125 total loss from advertising restrictions in Oklahoma.

*/ Where W = dead-weight loss, R = total revenues spent on eyeglasses, e = elasticity of demand for eyeglasses and PD = the price distortion from advertising restrictions.

SUBMITTED BY RICHARD KLEIN

LADIES AND GENTLEMEN OF THE COMMITTEE

My name is Richard Klein and I am representing The New Jersey Press Association.

The Association completely supports passage of A-3262, A-3264 and A-3273 because we believe it is in the best interest of the general public to have competitive pricing information at their hands in the most convenient way possible. This method is advertising.

Before I go into depth on our position, let me say a few words about the press association. It was founded in 1856 and is the oldest continuous newspaper association in the nation. Currently, our membership is comprised of all 28 daily newspapers in the state and 85 precent of the weekly newspapers.

I am a former president of the association.

Today you are being asked to consider legislation that would benefit the citizens of the State of New Jersey. You are being asked to consider legislation that would permit the advertising of prescription drug prices and the advertising of optical prices.

These two areas are currently forbidden under state law as "unethical".

In our opinion, we can see nothing that would cause advertising to be unethical in this day and age.

We have heard all the objections raised by the professional groups representing the pharmacists and optomotrists--and we find their objections extremely weak.

There is statistical data available that supports the claim that advertising does indeed lower the prices of prescription drugs and eyeglasses.

There is little to the claim that lower quality materials will be used. It is our understanding that most optometrists and those engaged in the optical field purchase their materials from the same suppliers. The tolerances for these materials is manadated under federal law.

This ban on advertising is a method to protect a small group of citizens in this state from having to compete in the open economy. This ban protects them from having to be concerned with the economic facts of life that, as we all know, help strengthen the economy.

It protects them at the expense of the vast majority of the citizens of this state who are forced to pay outlandish prices for necessary services. It has been estimated by the state Division of Consumer Affairs that prescription drug prices can be as high as 1200 percent over where they should be if advertising

were permitted. And who normally gets the benefit of this vastly inflated prices? Not those who need it most ladies and gentlemen--the aged, the sick and the infirm, but the professionals.

Advertising would help cure this problem by forcing those in the professions to compete and the consumer would get the best price possible--and the professional would also have a decent profit.

Finally, and this is perhaps the most serious aspect of the current law which these bills would remedy, we believe the current law is blatantly unconsitutional.

This law deprives those who wish to excerise their right of free speech, granted under both the state and Federal consitutions, from doing so. It is a law that goes entirely against the principles that this nation was founded upon. It says "you are forbidden to advertise" " you are forbidden to take advantage of those rights our founding fathers guaranteed under the constitution.

And, you are forbidden to do so because we must protect a special interest group.

The current law also goes against the free enterprise system which is a bulk-work of our national and state economy. A system which provides that each person enters the market place on a competitive basis.

Ladies and Gentlemen, you have the power to release these bills

We encourage you to do so.

NEW JERSEY DENTAL ASSOCIATION

STREET ADDRESS: 2675 U. S. HIGHWAY ONE, RFD 4, NORTH BRUNSWICK, N. J. 08902
MAILING ADDRESS: P. O. BOX 1715, NORTH BRUNSWICK, N. J. 08902 (201) 821-9400

TESTIMONY BEFORE ASSEMBLY COMMERCE, INDUSTRY
AND PROFESSIONS COMMITTEE,
REGARDING ADVERTISING FOR
PHARMACISTS AND OPTOMETRISTS

May 22, 1975
Seton Hall University
Newark, New Jersey

By
Mr. Gary Shenfeld
Director of Communications - Dental Care Programs

FIRST, LET ME INTRODUCE MYSELF; MY NAME IS GARY SHENFELD, I AM DIRECTOR OF COMMUNICATIONS AND DENTAL CARE FOR THE NEW JERSEY DENTAL ASSOCIATION.

THE ASSOCIATION REPRESENTS MOST OF THE FIVE THOUSAND ACTIVE, PRACTICING DENTISTS IN THE STATE OF NEW JERSEY.

WE ARE TESTIFYING TODAY BECAUSE WE FEEL THE BILLS REFERRED TO AT THIS PUBLIC HEARING REPRESENT A RETREAT FROM PROFESSIONALISM, AND WOULD BE DETRIMENTAL TO THE BEST INTERESTS OF THE PUBLIC WHICH WE SERVE.

TO OUR KNOWLEDGE, THERE IS NO PROOF THAT PRICE ADVERTISING REDUCES THE COST OF HEALTH CARE.

EXPERIENCE HAS SHOWN THAT ADVERTISING PRICES AND PERMITTING PROFESSIONAL PRACTICES IN RETAIL OR COMMERCIAL STORES LOWERS THE QUALITY OF HEALTH CARE DELIVERED.

WE FEEL IT IS UNPROFESSIONAL FOR ANY PROFESSION TO ADVERTISE, INCLUDING THE LEGAL PROFESSION.

ALL PROFESSIONS HAVE A CODE OF ETHICS. THE CANNONS OF ETHICS OF THE BAR ASSOCIATION PROHIBIT ADVERTISING.

THE AMERICAN DENTAL ASSOCIATION IS AGAINST INDIVIDUAL MEMBERS ADVERTISING AND CALLS IT "UNETHICAL." IT IS ALSO "UNETHICAL" FOR A DENTIST TO LIST FEES AND TO POST THEM.

SECTION 12, OF THE AMERICAN DENTAL ASSOCIATION'S "PRINCIPLES OF ETHICS" STATES: REGARDING ADVERTISING:

"ADVERTISING REFLECTS ADVERSELY ON THE DENTIST WHO EMPLOYS IT AND LOWERS THE PUBLIC ESTEEM OF THE DENTAL PROFESSION. THE DENTIST HAS THE OBLIGATION OF ADVANCING HIS REPUTATION FOR FIDELITY, JUDGMENT AND SKILL SOLEY THROUGH HIS

PROFESSIONAL SERVICES TO HIS PATIENTS AND TO SOCIETY.

THE USE OF ADVERTISING IN ANY FORM TO SOLICIT PATIENTS IS INCONSISTENT WITH THIS OBLIGATION."

THE NEW JERSEY STATE BOARD OF DENTISTRY, IN JANUARY OF 1962, ISSUED A STATEMENT INTERPRETING THE DENTAL PRACTICE ACT STATING IN PART:

"THEREFORE, THE STATE BOARD OF REGISTRATION AND EXAMINATION IN DENTISTRY HAS RESOLVED THAT A LICENSED DENTIST IS NOT PERMITTED TO PLACE AN ADVERTISEMENT IN NEWSPAPERS, MAGAZINES, PERIODICALS, JOURNALS OR PROGRAMS IN WHICH HIS NAME, ADDRESS, OR NAME, ADDRESS AND TELEPHONE NUMBER, APPEARS.

THIS RESOLUTION INCLUDES ALL NOTICES, INCLUDING THOSE DENOTING OPENING OF OFFICE, CHANGE IN ADDRESS, RETURN TO PRACTICE, ENTERING A SPECIALTY, AND SO FORTH."

(END OF QUOTE)

I WANT TO EMPHASIZE PROFESSIONALISM, BECAUSE PROFESSIONALISM IS IMPORTANT TO THE PATIENT.

WEBSTER'S DEFINES A PROFESSIONAL AS: "OF OR PERTAINING TO A PROFESSION AS PROFESSIONAL ETHICS." AND PROFESSIONALISM AS: "CONDUCT, AIMS, QUALITY CHARACTERISTICS OF A PROFESSION."

WHEN YOU GET TO THE POINT WHERE THE PROFESSIONS ARE FIGHTING AMONG THEMSELVES, BASED ON ADVERTISING AND COST TO THE PATIENT, THE INEVITABLE RESULT IS A DECLINE IN THE QUALITY OF HEALTH CARE DELIVERED.

THERE IS NO QUESTION THAT FEES FOR ANYTHING CAN BE REDUCED. BUT WHEN YOU REDUCE FEES - YOU REDUCE QUALITY.

TO USE DENTISTRY AS AN EXAMPLE: YOU CAN GET A CAP FOR A TOOTH THAT COSTS LESS AND LAST FIVE YEARS.

IT DOES NOT LAST A LIFETIME LIKE THE CAP A DENTIST WOULD NORMALLY PUT IN THE MOUTH.

THE CHEAP CAP, BY THE WAY, DISCOLORS, CRACKS, LOOKS BAD AND REALLY IS OF NO ADVANTAGE TO THE PATIENT, EXCEPT - IT COSTS LESS.

YOU CAN DO THINGS RIGHT OR YOU CAN DO IT CHEAP.

THE NEW JERSEY DENTAL ASSOCIATION OPPOSES MANDATORY ADVERTISING AND POSTING PLANS REGARDING PHARMACISTS AND OPTOMETRISTS. WE FEEL THESE BILLS BEING CONSIDERED TODAY ARE UNETHICAL AND UNPROFESSIONAL.

WE DO NOT WANT TO RETURN TO THE SO CALLED "GOOD OLD DAYS" WHEN QUAK DENTISTS, INCLUDING TOOTH-DRAWERS, CHARLATANS, WANDERING STORY TELLERS AND EVEN HANGMEN INVADED THE FIELD OF DENTAL PRACTICE.

WE DO NOT WANT TO RETURN TO THE DAYS OF MEN LIKE "PAINLESS PARKER," WHO ADVERTISED WIDELY AND CONTINUOUSLY, AND WHO MOVED FROM TOWN TO TOWN SELLING TOOTHACHE CURES AND EXTRACTING TEETH.

IN THE RECENT PAST, SOME DENTISTS IN OTHER PARTS OF THE COUNTRY USED ADVERTISING TO CREATE THE APPEARANCE OF MORE REASONABLE SERVICES. BUT IN REALITY, THEY SET SERVICES UP ON A CREDIT BASIS CHARGING MAXIMAL RATES OF INTEREST.

A FEE PAID OFF OVER A LONG PERIOD OF TIME, AT MAXIMAL INTEREST RATES, ACTUALLY COSTS MUCH MORE THAN GOING TO SEE AN ETHICAL DENTIST AND PAYING HIM HIS USUAL FEE.

HOW WAS THE INTEREST OF THE CONSUMER SERVED OUT THERE?

THE BRIGHT, THE INTELLIGENT, THE SOPHISTICATED COULD SEE THROUGH THIS GUISE AND REALIZED THEY WERE BETTER SERVED BY THE ETHICAL PRACTITIONER.

SADLY, IT WAS THE POOR, THE LESS EDUCATED, THE LESS SOPHISTICATED THAT FELL PREY TO THOSE WHO USED ADVERTISING AS BAIT FOR THEIR EXPENSIVE PROCEDURES.

THANKFULLY, THE PUBLIC INTEREST IN NEW JERSEY IS PROTECTED NOT ONLY BY THE CODE OF ETHICS OF YOUR DENTAL ASSOCIATION, BUT ALSO BY NEW JERSEY STATUTES AS EXPRESSED IN DENTAL PRACTICE ACT. TITLE 45.

OUR INTEREST IN APPEARING HERE IS TO EXPLAIN THE ETHICS OF OUR PROFESSION AND HOPEFULLY TO KEEP IT THAT WAY, NOT ONLY FOR THE DENTAL PROFESSION, BUT FOR ALL PROFESSIONS AND IN THE PUBLIC INTEREST.

THANK YOU

STATEMENT OF MARVIN R. FRIEDMAN, RP

My name is Marvin Friedman. I am a pharmacist, living and working in Bergen County. I was present at the public hearing of the committee in Newark, May 22nd, 1975, and heard statements made by the staff member of the FTC and by Mrs. Virginia Annick. With reference to the statements made by the representative of the FTC, I noted certain discrepancies and omissions, which I would like to call to your attention. No mention was made by him of the existing discriminatory pricing procedures engaged in by several pharmaceutical manufacturers. It is obvious that if one pharmacy pays more for a given drug than another, the price of the prescription to the patient is also going to be different. No mention was made of the fact that the FTC, despite its duty to uphold and enforce the laws of this country, has and continues to fail to enforce the provisions of the Robinson-Patman Act. In Portland, Oregon, due to the initiation of certain HMO's, approximately half of the pharmacies there were forced to close their doors and go out of business. The remaining pharmacies banded together, and instituted suit against the pharmaceutical manufacturers. This suit has been decided in favor of the pharmacists in each court where it was brought, on appeal from the defendents, and is now awaiting hearing before the Supreme Court of the US. The FTC, being obviously derelict in its duty, is scarcely in a position to make any recommendations to any group or legislative body regarding anything.

On the other hand, Mrs. Annick made several valid points. She stated, and quite correctly, that certain categories of the public, the senior citizen, and the very poor, are not terribly mobile, and therefor find it difficult to travel to shop and compare prescription price. Mrs. Annick overlooked that it is that same lack of mobility which prevents those same people from traveling to a chain or supermarket discount pharmacy at the present time. To assume that any amount of advertising would have any effect on this situation is patently erroneous. Mrs. Annick stated that a counter argument against advertising had been the possibility of violations of laws or ethics, to cut costs, resulting in lower prices, and quite rightly stated that this should not be a consideration, as the professional boards have the responsibility and punitive powers to detect and correct any such situation. The same logic, however, should apply to her contention that advertising would reduce prescription prices. The existence

of advertising in other businesses has not necessarily resulted in lower prices uniformly. Such items as automobile tires, food, clothing, etc, while widely advertised, still indicate a wide disparity of prices among various purveyors. Therefor, I submit that the assumption that advertising would result in lower prescription prices is not valid. I might add, that in states, such as Florida, where prescription price advertising is permitted, not only do I not know of any significant price differential from other states, but I point out that the overwhelming majority of pharmacies in Florida are chains. There are relatively few independent community pharmacies in that state, as opposed to other states. Having been associated with chain and discount pharmacies myself for a number of years, I can speak of their operations with knowledge and authority. Generally, they can and do purchase drugs, at discounts ranging from 10% to 25% better than the average community pharmacy. Because their overhead is generally less, and their services minimum, their prices can be, and are, less. The availability of such pharmacies, and their distribution throughout the state, are well known. Again, lack of mobility of individuals is only one of many factors whereby the community, independent pharmacy, continues to be viable. The discount chain pharmacy generally operates on a gross profit of 38%-40%, as opposed to the independent operating on 40%-45%. Although the difference in price charged to the consumer is greater than this difference, it is easily explained by the differences in costs of medication and drugs. This reverts back to the discriminatory pricing procedures of some manufacturers. Mrs. Annick would be better advised to investigate this situation, and attempt remedial action therein, than anywhere else.

Mrs. Annick also mentioned the prescription price survey undertaken by her, and the results thereof. Certainly, there are a few pharmacies which overcharge their patrons, and I agree wholeheartdly that this is deplorable. However, using her own logic regarding possible violations of law and ethics being controllable by the professional boards, the premissiveness of advertising will have little or no effect on this situation. I would be more inclined to agree that the setting of a permissable price range, which could be charged by a pharmacy, would correct this situation, provided that there was not as wide a disparity of wholesale drug costs as

now exist. However the pharmacist who is going to be unmerciful in overcharging the public is not going to change because of any advertising. Even the discount chains, who use certain drugs as "loss leaders", and charge their cost, or a few pennies over their cost make up the differences on other drugs. Many businesses use these "loss leaders" to invaigle people into their establishments, hoping that once they are inside they can be sold other not profitable items, in addition. I would estimate that I have about 3000 drugs in various forms and strengths in my pharmacy. How many of these could any pharmacy advertise?

It is a fact, from the US Dept. of Labor, that over the past few years. the consumer price index has risen 55%, compared to prescription prices having risen 5%. When you add the fact that todays prescription contains larger quantities, and more doses than its counterpart of yesterday. you arrive at the startling conclusion that todays prescription, per dose. costs LESS than it did 5 years ago.

The same source of information indicates that the average family spends 0.8% of its annual income for prescription drugs. A family with an income of $10,000 per year, would spend $80 per year for prescriptions. A family with an income of $15,000, would spend $120. Of course there are families which spend much more, and many who spend much less. Let us assume that we could. by any means feasible, reduce prescription prices by a modest figure of 10%. These same two families would save respectively, $8 and $12 per year. very insignificant figures. Now look at the average pharmacy. According to Lilly Digest reports. the average pharmacy does about 50% of its volume in prescriptions. and shows a net profit before taxes of 3.6%. Ten percent of its prescription volume is equivalent to 5% of the pharmacies total volume. However, since the pharmacy shows only 3.6% profit before taxes, the average pharmacy would then be operating at a loss. Noone can long remain in business on that basis.

Let's look at the situation from another viewpoint. I, and a few other pharmacies in Bergen County, actually calculated our cost of filling a single prescription. Figures were taken from the preceding years P & L statement, and necessary adjustments were made. My personal figures were submitted by me to Blue Cross, as evidence that a fee increase was necessary. Although the results of the various pharmacies calculation were not identical, they were very similar, and in each instance, the figure arrived at was in excess of $3. Medicaid reimburses us with a fee of $2.15, Paid Prescription the same. and Blue Cross recently gave us a 20¢ increase to arrive at a fee of $2.35 Most of the pharmacies work on a fee in the area of $2.75 for their private sector patients. It is therefor obvious that the prescription department of a pharmacy is being subsidized by the other items of general and cosmetic merchandise.

There are those who assume that pharmacists are waxing rich on the unsuspecting public. I know of very few rich pharmacists, and they didn't make their wealth in pharmacy. I personally believe that my prescription prices are fair and average.

I consider my services to my community the best that I can make them. With a partner, I operate a reasonably successful pharmacy in New Milford in Bergen County. I earn less than $20,000 a year, and for this, I have the privilege of working 55-60 hours a week, with an investment in inventory and fixtures in excess of $70,000. I would neither encourage nor permit my children to follow my footsteps, and enter the profession of pharmacy. While I find the personal rewards gratifying, the monetary rewards are scarcely consonant with the education requirements and subsequent working conditions.

Permissive advertising could only result in price wars, which, especially in view of discriminatory pricing policies of some manufacturers. could only result in the local community pharmacy following in the footsteps of the local "mom & pop grocer" - dead and buried. If this were to be permitted to happen to pharmacy, the public would really suffer.

I would urge the Division of Consumer Affairs to direct its attention to those few pharmacies which are engaged in milking the public, and attempt to devise some method of constraining them, rather than attacking the entire profession. Pharmacists are overworked, over-regulated, over-attacked by consumerists, government agents, and legislators who are unaware of the multitude of problems which we face, and I at least. am over-weary of the whole mess. Let's go after those individuals who are operating unethically, illegally, or unmercifully, and leave the rest of us alone in our attempt to make a living.

Testimony of Alice Cohan, Executive Director,
New Jersey Public Interest Research Group, before
the Assembly Commerce, Industry and Professions
Committee of the N.J. Legislature, May 22, 1975.

Good morning. I am Alice Cohan, Executive Director of the New Jersey Public Interest Research Group. NJPIRG is a non-partisan, non-profit, student-funded and student-directed research corporation, supported by over 20,000 New Jersey college students.

In the past few months we have presented this committee and in some cases the entire legislature with our views on prescription drugs. Simply stated our view is that the cost of prescription drugs is artificially high. One of the reasons that prices are artificially high is because pharmacists by law cannot advertise and the consumer's access to price information is limited. This limitation has lead to non-competitive pricing. We have presented to this committee a survey taken by our organization of all pharmacies in the city of New Brunswick. This survey documents the broad price variations from store to store for the same prescription.

It isn't easy to conduct a survey of prescription drug prices in a given area of New Jersey. NJPIRG attempts to conduct such surveys in the past have run into what seemed at time to be insurmountable objects. Pharmacists usually will not quote prices over the phone or even in person unless a prescription is presented. Some pharmacists demand that they initial a prescription if they quote a price. One pharmacist even demanded that he keep the prescription after he quoted a price. In short, it is nearly impossible to comparison shop for prescription drugs in this state.

We have now, however, completed a comprehensive and meaningful survey of various prescription drug prices at each pharmacy in the city of New Brunswick. We believe the situation in New Brunswick is typical.

Rather than read the whole survey, I have entered a copy into the record (note Appendix A). I will simply state that the PIRG case study of all seven pharmacies

in the city of New Brunswick compared the prices of ten prescription. In no case was the price variation of a single drug between the seven pharmacies less than $1.50, and the greatest variation was $4.50. Although the N.J. Pharmaceutical Association criticizes our survey, they offer no surveys to dispute our results. Their resources could provice a universal analysis of price variation. However, PIRG contends that our survey is valid. It is reality for consumers in New Brunswick who have no other shopping alternatives. The Pharmaceutical Association is quick to refute any surveys done by Public Interest Groups, calling them too narrow in scope or statistically unsound. This merely clouds the issue. Rather, the opponents should be asked to prove that price variations do not exist and that consumer access to price information would not improve this situation. As indicated by comparisons of the high sale price column to the law sale price column, it would pay for consumers to be able to shop around for prescription drugs. Unfortunately laws prohibiting advertising by pharmacies severely restrict what is taken for granted in this country: the ability to comparison shop.

Specifically in reference to the legislation being considered today, I would like to review each of the three bills affecting prescription drugs.

First is A1228. NJPIRG supports the concept of this bill requiring the posting of the 100 most frequently used prescription drugs or medicines by pharmacies and drug stores. However, we question why the bill arbitrarily stops at requiring only 100 drugs to be listed. Why should a consumer be denied price comparison information because he or she needs a drug that happens to be the 101st most frequently used drug? What is to stop the pharmacist with the lowest prices for the top 100 from having the highest prices for all the rest of the prescription drugs?

The Assembly Commerce, Industry and Professions Committee in a work session has responded to this concern by considering amending the bill to read that "upon request, each pharmacy, drugstore, or drug department shall provide customers with the current total retail price of items not included on the list." PIRG does not

feel that such an amendment would adequately resolve the problem, but is rather a compromise. We would recommend that in addition to price positihg the legislature call for a compiling of a catalog that would list all FDA approved pharmaceuticals in this state. Such a catalog would include the price that the particular pharmacy would see the prescription drug and whether or not that pharmacy carried the drug. In Canada, a similar catalog already exists. PAR Cost (Prescriptions at a Reasonable Cost) is a catalog of substitutable generic drugs in Ontario, Canada. The most logical organization for the catalog would be by generic type in alphabetical order. This implies that doctors would prescribe by generic type and supports the concept of generic substitution as described in Assemblyman Herman's bill, A1257.

At this time, I would like to mention that PIRG supports the concept of generic substitution. However, we recognize the importance of the passage of legislation requiring mandatory price posting for pharmacists prior to or as a package with such a generic substitution bill. This would ensure that pharmacists would not substitute higher prescription drugs than those called for by a prescription. A1257 states that "no drug interchange shall be made unless a savings to the consumer results." This implies that if a substitution is made it must reflect a savings to the consumer but the substitution does not necessarily have to be made. The decision to substitute should not be completely left up to the discretion of the pharmacist. It would therefore be essential for the consumer to have ready access to price comparison information to facilitate choice.

Thus NJPIRG supports adequate price listing as a first step to improving the situation for consumers of this state in the area of prescription drugs.

The other two bills dealing with the prescription drug issue under consideration today are A3273 and A736. PIRG views these bills as essential enabling legislation to A1228. Both bills amend the statute 45:14-12 to allow for the advertising of the retail prices of prescription drugs. It is PIRG's interpretation of the current

statute that it would require amendment to allow for even the price posting of drugs as described in A1228. Beyond this, the bills would allow for general advertising of prescription drugs.

The issue of restriction on advertising of retail prescription drugs has long been of concern to consumers. Rather than delve into the history of the controversy we will focus here on two definitive statements on the issue from the U.S. Department of Health, Education and Welfare and the U.S. Department of Justice.

The Second Interim Report and Recommendations of the Task Force on Prescription Drugs of the U.S. Department of Health, Education and Welfare stated,

> "There is an obvious need for patients to be able to determine readily the prices charged by the various pharmacies in their community. This appears to be particularly important in the case of long-term maintenance drugs.
>
> The task force recognizes the difficulties in making such information easily available....
>
> Nevertheless, if the patient is to maintain the right to select a pharmacy, he also has a right to know prices it charges and to compare these with other prices."

The Research Paper and Policy Statement of the U.S. Department of Justice Regarding State Restrictions on the Advertising of Retail Prescription Drugs concurred with the H.E.W. paper. The Department of Justice stated, "...Competition is our basic national policy. It has proven to be the most effective spur to business efficiency, innovation, and low prices. Prohibition on drug advertising represents departures from this National Economic Policy."

The Justice Department paper concludes,

> "Accordingly, it is the Department's view that existing state legislation or regulations which prohibit or restrict price advertising of prescription drugs may well be adverse to the public interest. Since such restrictions appear to be unnecessary to protection of the public and result in justifiable expenditures by consumers, the Department feels they should be eliminated."

Opponents to advertising of prescription drugs claim that price comparisons fail to consider the quality of service, record keeping, and home delivery. Granted, quality is an important factor in buying to many consumers whether they are purchasing a car, canned fruit, or a new suit. However, in other business areas the consumer can comparison shop and enjoy the freedom of choice. Why is this right denied when shopping for prescription drugs? Also, we are told that advertising of prescription drugs would force many pharmacies out of business. Are consumers being asked to subsidize inefficient operations?

Of the two bills, PIRG would prefer A3273. This bill would delete all of Section C in the relevant statute, thus permitting the advertising of retail prices of drugs and also the use of such terms as "cut rate," "discount," "bargain."

Allow me to cite an example to explain our position. The Revco Discount Drug Centers used as its biggest promotional tool a Senior Citizen 10 percent Discount Plan for people at least 60 years old. Revco bought out a Virginia drug chain in 1967 and began to advertise the discounts. Under pressure from other pharmacists and the Virginia Pharmacy Board the legislature passed a law banning discount advertising. The law was used to stop the Revco Senior Citizen Discount Plan. Surely, we all recognize that in these time of recession, discounts and any other form of price relief should be welcomed, particularly for Senior Citizens who often need long-term maintenance drugs and must buy them on a fixed income. Certainly, PIRG is not advocating misleading advertising, but the state statutes should protect against this anyway.

In summary, NJPIRG would ideally recommend a comprehensive bill encompassing all the major issues dealing with prescription drugs and the consumer, including: price listing of all prescription drugs, advertising of prescription drugs, and generic substitution. If not dealt with as a total package, we recommend due consideration of each of these important issues. Today, the cost of prescription drugs is artificially high due to restraints which impede normal price competition. Action on all of these issues are necessary to rectify this situation.

Thank you for your consideration.

Variation of Selected Prescription Drugs Price in New Brunswick Pharmacies*

	Phar. #1	#2	#3	#4	#5	#6	#7	High	Low
Achromycin #20 200 mgm capsules	3.00	3.95	2.65	--	4.00	3.35	3.10	4.00	2.65
Pantid #20 400 tablets	3.25	5.25	3.25	6.95	3.95	4.45	4.65	6.95	3.25
Ortho-Novum 1/50 21 1 cycle	2.50	3.75	2.49	2.95	3.00	2.50	2.95	3.75	2.49
3 cycle	7.50	9.25	7.50	8.85	8.50	7.45	8.50	9.25	7.45
Orval 1 cycle	2.50	4.25	2.49	2.95	3.00	2.45	2.95	4.25	2.45
Orval 3 cycle	7.50	10.50	7.50	8.85	8.50	7.25	8.50	10.50	7.25
Diamox 250mg	6.50	8.50	7.00	8.50	7.00	8.50	8.55	8.55	6.50
Cyclogyl 15cc 1%	7.50	8.25	6.50	7.95	8.00	8.75	7.95	8.75	6.50
Pelocarpine 2% 15cc	2.75	4.75	3.95	7.25	3.95	4.75	3.85	7.25	2.75
Mycorkan Vaginal Tablet #30	6.50	6.95	5.20	5.95	6.00	6.85	7.25	7.25	5.20

*We do not include the actual names of the pharmacies.

U.S. Prescription Drug Prices

(Based on a Consumer Federation of America survey of 147 pharmacies in 81 communities in 17 states and the District of Columbia, July-August, 1972.)

Quantity & Drug	High	Low	High is 0.00 times Low*	Median**
100 Achromycin V 250mg	$17.94	$ 3.47	$ 5.17	$ 6.50
100 Actifed Tablets	10.00	2.99	3.34	5.95
100 Benadryl Kapseals 50mg	6.35	2.77	2.29	4.00
100 Darvon compound 65mg	15.00	7.15	2.09	9.00
100 Diuril 500mg	11.25	5.09	2.21	6.95
100 Equanil 400mg	13.15	4.60	2.85	7.90
100 Flagyl 250mg	25.00	9.20	2.70	17.00
10cc Insulin Lilly U-80 (All types)	2.85	1.65	1.72	1.99
10cc Insulin Squibb U-80 (All types)	2.98	.88	3.38	1.89
15mg Mycolog cream	5.55	3.04	1.82	4.25
100 Ornade Spansule	20.00	8.90	2.24	11.10
100 Penicillin G 400,000 units	15.00	1.50	10.00	4.75
100 Pentids 400	15.95	6.50	2.43	11.59
100 Premarin 1.25	15.89	6.09	2.60	7.75
100 Ser-Ap-Es	13.65	6.45	2.11	8.97
100 Sumycin 250mg	10.00	4.05	2.46	6.00
100 Tetracycline 250mg	20.00	2.50	8.00	4.75
100 Thyroid 1gr	3.90	.63	6.98	1.25
100 Tuss-Ornade Spansule	20.00	5.00	4.00	12.85
100 Valium 5mg	15.00	6.75	2.22	9.38

*That is, the consumer paying the highest price for Achromycin ($17.94) pays 5.17 times as much as the consumer paying the lowest price ($3.47).

**That is, as many pharmacies charge more than $6.50 for Achromycin as charge less than $6.50.

Groups surveying were: Arizona Consumers Council, Connecticut Consumer Assn., Consumers Assn. of Indiana, Southern Illinois University, American Federation of State, County & Municipal Employees, Greenbelt Consumer Services, Assn. of Massachusetts Consumers, Michigan Credit Union League, Alliance for Consumer Protection, Ohio Consumer Assn., Consumer Protection Assn. (Cleveland, Ohio), Oregon Consumer League, Wyoming Consumer United Program.

Founded 1821

THE PHILADELPHIA COLLEGE OF PHARMACY AND SCIENCE

43rd Street, Woodland Avenue & Kingsessing Mall / *In University City*
PHILADELPHIA, PENNSYLVANIA 19104 / *Phone:* (215) EV 6-5800

June 10, 1975

The Honorable Byron Baer, Chairman
New Jersey Assembly Committee on
Commerce, Industry and the Professions
Trenton, New Jersey 08608

Dear Assemblyman Baer:

I am writing to you in reference to A. 1228 (which would require posting of prescription prices in pharmacies) and A. 3273 (which would permit prescription price advertising). I regret that my schedule did not allow me to present my views in person when your Committee held public hearings, but hope that through this communication they can be given consideration.

I applaud the proposed intent of these bills as a recognition that a patient has the right to know the charge for a prescription before it is dispensed, but feel that neither proposal effectively informs the consumer and, further, may actually result in an unnecessary increase in prescription charges in the State of New Jersey.

It is recognized that some small minority of patients do find the costs of prescribed medication to be a financial burden. I must emphasize, however, that we should be focusing on the value of the prescription services the patient receives rather than on their cost alone. The alert pharmacist practicing at a high level of performance can actually save the patient money even though he may charge a higher price for a given prescription. This can be done by his not dispensing prescribed medication that may be duplicative of that which the patient is already taking, by not dispensing prescribed medication that is unnecessary, or by not dispensing prescribed medication which may interact with other medication causing the patient additional illness or possibly hospitalization. The pharmacist can do this only with a proper knowledge base, the proper use of patient medication records, and only if the pharmacist has available information on all medication the patient is taking.

By informing the patient only about the price of a particular prescription, it is assumed that more patients will select a pharmacy for a particular prescription on the basis of the pharmacist's charge for that particular prescription. This does not encourage the pharmacist to seek to expand and utilize the available knowledge of therapeutics for the benefit of the patient. It further may encourage the patient to utilize more than one pharmacist with

the result that any one pharmacist may not have a complete record of the patient's drug utilization and cannot effectively monitor the patient's drug use for the patient's economic benefit and benefit to the patient's health.

An obvious deficiency in either price posting or advertising is that it provides incomplete information, since it is impractical to post or advertise the price for all medications, in all available dosage forms, in all available strengths, and in all quantities which may be prescribed. Thus, a system by which the patient may obtain a price quotation for his individual prescription (along with an explanation of the pharmaceutical services included in that price) would seem to be of more benefit to the individual patient.

Another factor is the frequent lack of knowledge on the part of the patient concerning exactly what the prescribed medication is. For example, most patients would not distinguish between Penicillin G and Penicillin VK. To the average patient these likely would be considered to be "just penicillin", although the latter may be ten or twenty times more expensive than the former.

Additionally, either approach may lead to "loss leader" pricing in which a low charge is made for the advertised or posted medication (drug, dosage form, strength, and quantity) but an abnormally high charge may be made for all other prescriptions.

With respect to prescription price advertising, one cannot ignore the increasing problems associated with drug misuse (both through prescribed medication and through illicit drug use). The advertising of prescription prices in the same manner as is used for bread, milk, eggs, etc., can do little to encourage the public to have a respect for drugs as medications to be used to treat specific disease states and would, in fact, encourage the misconception that drugs (like food) are an everyday part of our lives.

Finally, one cannot ignore the cost of prescription drug advertising. In Pennsylvania, where such advertising has been legal since 1971, there is currently (to my personal knowledge) no advertising of specific prescription prices in any of the major media in the state. Those who initially advertised when it became legalized have apparently discovered that the cost of the advertising was too large to continue the practice.

New Jersey has been characterized as a leader in consumer protection in the field of pharmacy. It has been in the forefront in requiring that pharmacists participate in continuing education and maintain patient medication records. The New Jersey Commission on Pharmacy is the only professional licensing board in the state with consumer representation. I applaud and encourage continuation of these progressive steps.

As noted above, however, I feel that A. 1228 and A. 3273 are regressive steps in consumer protection. These methods have not been shown to be effective in lowering prescription charges (and may, in the case of

advertising) result in higher charges. More significantly, they focus entirely on price and not on value. The latter focus should, in fact, result in both lower prices for medication (by eliminating unnecessary medication) and better health (by reducing drug interactions). While I am in full agreement with the consumer's right to know in advance the charge for a prescription, the consumer also should know the pharmaceutical services being provided for that charge.

I thank you and your committee for the opportunity to express my views on these issues and will provide your committee with any possible assistance you may request.

Sincerely yours,

Maven J. Myers

Maven J. Myers, J.D., Ph.D.
Professor of Pharmacy Administration

MJM:de

STATE UNIVERSITY OF NEW YORK
State College of Optometry

122 East 25th Street
New York, New York 10010

212-673-4500

May 22, 1975

Testimony of Dr. William C. Folsom before the New Jersey State Assembly Committee on Commerce, Industry and Professions.

Mr. Chairman, distinguished members of the Assembly Committee on Commerce, Industry and Professions.

My name is William C. Folsom. I am an Assistant Clinical Professor and Chief of the Ophthalmic Dispensary of the College of Optometry, State University of New York.

From 1948 to 1968, I practiced optometry in Jamaica and Brooklyn, New York providing care in General Optometry, Contact Lens Fitting, Vision Training, and Sub-Normal Vision.

In 1968, I was employed on a part time basis by the standards and evaluation section, Medicaid, Department of Health, City of New York where I now serve as Deputy Director of Optometry. In this position, I have written several papers relating to optometry and public health. "Standards of Eyeglasses" was published in Medical Care the publication of the medical section of the American Public Health Association.

I would like to present my concern as an optometric educator and a public health official that assembly bill 3263 which permits full scale advertising of optometric fees and services; permits optometrists to be employed within retail establishments; and permits optometrists to be employed by non-optometric corporations, individual opticians or any other lay persons is not in the best interest of the residence of the State of New Jersey.

Optometric education today offers a well organized and comprehensive program in four major areas:

Behavioral Sciences and Public Health
Basic Sciences
Basic Vision Sciences
Clinical Optometric Sciences

It provides the optometrist with the expertise to render comprehensive vision care services. His examination, diagnosis and prescribing are directed:

1. To enable his patient to see clearly and efficiently

at both distance and near without strain or discomfort,

2. To prevent subsequent vision problems and disfunction,

3. To maintain good vision over an extended period of time,

4. To train in proper eye care and exercise,

5. To meet specific vocational and avocational vision needs directly related to general and eye safety, efficiency, and productivity,

6. To identify ocular pathology and systemic pathology through ocular manifestations,

7. To refer to the other health care professions for evaluation and treatment of disclosed health problems,

8. To provide continuing care of contact lens patients to avoid permanent eye damage which can result from improper fitting contact lenses,

9. To provide low vision aids for patients whose best corrected acuity in either eye is 20/70 or less,

10. To provide training in the use of low vision aids to return sub-normal vision patients to a more productive place in society,

11. To provide vision training and orthoptics for patients with ocular muscle discrepencies which are often accompanied with learning disabilities.

In my work with the New York City Medicaid Program, it has been my experience that optometric care tends to be limited in scope to refractive evaluation, and to over utilize the provision of low powered eyeglasses when fees are fixed and the milieu of practice is commercial or a shared fee for service facility - A ping ponging parlor. A study demonstrating significant differences in care provided in private offices, share facilities, and retail optical outlets will appear in the next issue of Medical Care.

Assembly bill 3263 would result in a reduction in the quality and scope of vision care for the residence of New Jersey as it would further improperly identify vision care with eyeglasses and polarize the provision of care in a milieu which would not be prepared to provide more than examinations primarily directed towards the provision of eyeglasses. The other skills and expertise of those licensed by the State of New Jersey as optometrists to provide vision care would be lost to the public.

Further, Assembly Bill 3263 will result in a reduction in the quality of the eyeglasses which are provided in the State.

Aside from the Food and Drug Administration's regulation concerning the impact resistance of lenses, there are no laws or regulations which set standards for either ophthalmic materials, frames and lenses, or the finished eyeglasses.

The New York City Medicaid programs has attempted to continue the quality of eyeglasses by limiting the ophthalmic materials used in their fabrication to the top of the line, name brand, products of primary ophthalmic manufacturers, and the American Optometric Association's standards for fabrication. The ophthalmic materials have been monitored by requiring the original manufacturers' frame and lens packaging be attached to the providers invoice. A procedure which has been successful. Fabrication has been evaluated by recalling patients and evaluating the care they received and the eyeglasses which were provided with respect to the standards. The incidences of discrepancies of all types, centering, base curves, multifocal segments, edging, inserting, etc. have been significant.

There was no relationship between the quality of care as preceived by the recipient and disclosed by the evaluation procedures. The consumer is ill equipped to judge the quality of the care and appliances which he receives.

Without its program of standards, monitoring, evaluation, and enforcement the quality of care and eyeglasses provided would be significantly lowered. The consumer does not have available to him the resources necessary to insure quality. Price advertising would further reduce his protection by providing a misleading fiscal incentive to obtain vision care where it is sure to be least comprehensive and of minimal quality.

STATEMENT TO THE ASSEMBLY'S COMMERCE, INDUSTRY AND PROFESSIONS COMMITTEE IN OPPOSITION OF ASSEMBLY BILL 3263. SUBMITTED BY: MEYER BURT, O.D.

I am opposed to ASSEMBLY BILL 3263 and am submitting for your consideration my reasons so that you will have a clear, concise understanding of the inherent danger to the visual welfare of the citizens of New Jersey.

I consider myself an expert witness by virtue of my years of practice as an optometrist in a commercial environment as compared to my practice today in a professional office. Following my graduation from college in 1943, I spent two years with Tru-Site Optical Company, six months with Ford Optical Company and twenty years with Tappin's Inc. -- a jewelry store in Camden, New Jersey. The past ten years I have conducted my own office in Camden. ASSEMBLY BILL 3263 deals with optometrists in commercial locations. I therefore will attempt to familiarize you with my twenty years of background experience on how an optometrist functions in a retail jewelry store.

The "optical department" was located in the rear of the store, in an area roughly 11' wide by 10' long, plus a small area for a desk. This included the examination and waiting rooms. The equipment and furnishings were supplied by Tappins and met the minimum standards of the State Board of New Jersey. I was responsible for and maintained a small portion of window space which displayed frames for glasses. My name appeared in the window facing Broadway and at the entrance to the optical department. To reach my office for an eye examination, the patient would pass through the main portion of the jewelry store -- past the credit department -- past boxes stored on the left and right to form an aisle, to sit on one of six chairs used for a waiting room. The cashier would push a buzzer to alert me whenever a patient arrived.

Today, this area is used for storage of merchandise. You can verify my facts by a visit to the store at 26 South Broadway, Camden.

I was told how much time to devote to each patient -- what laboratory (non-union) to use to fabricate the glasses -- what frames to use -- what type of lenses to use -- what prices to charge and the hours I had to be in attendance, which corresponded to the store hours. The business generated by the optical department was lumped with the store business. I was given monthly quotas and participated in cash and merchandise prizes if these quotas were exceeded. My salary was predicated on a base pay plus a percentage of the business of the optical department and a year-end profit sharing if the stores had a "good" year. It therefore became incumbent upon me to help as a jewelry salesman during the year and especially during the month of December, when I worked from 9-9:30 p.m from December 15th to 25th as an optometrist and jewelry salesman, for which I received a bonus.

In addition to my duties in Camden, I was made optometrist in charge of Tappins' Philadelphia offices. This was done to circumvent the laws of Pennsylvania. It was all very legal. An optometrist in Pennsylvania was not permitted to work for a lay person or corporation -- only for another optometrist. I employed and fired optometrists in name only. I paid a rental to Tappins -- maintained all the expenses of the office -- paid social security, unemployment compensation, workmans compensation and sent their wage taxes and withholding taxes to the proper authorities. At the Philadelphia office, the optometrists did the examining only. Tappins advertised glasses at a low price to generate volume, but used the bait-and-switch procedure by their

own employees to generate profit. Any losses I sustained running the Philadelphia department were added to my salary in Camden, plus of course, a fee for my services. I also shared in the profits of the dispensing department. Using this method, Tappins was always in full control of every activity in the optical department -- I was their conduit.

As a junior executive with the Company, I spent many days in Newark, at the main office of Tappins, Inc., learning lessons in economics from their comptrollers that are not taught in colleges of optometry. In computing net profits to arrive at my compensation -- allowances were made for store managers (who were my immediate bosses), area supervisors (secondary bosses), window and floor square footage devoted to the optical department, credit department expenses for collections and also losses, cost of advertising glasses, maintenances, insurance, taxes, depreciation, store expenses such as rent, heat etc., main office clerical help, executives at main office, return on investment and profit for the corporation. As a result of these meetings, I was told to make more money for myself it would be necessary to get a higher fee from the patients to off-set all these expenses. Inasmuch as I was now on a profit sharing basis, the message was quickly relayed to all persons connected with the optical department.

When New Jersey changed its laws and I could no longer be an employee, but had to maintain a separate and independent office on Tappins' premises -- the executives came up with an answer. I paid a rental to Tappins in New Jersey plus 25% collection fee for all credit patients. They tried, unsuccessfully, to have me pay them a percentage of my cash paying patients. I still maintained control of the Philadelphia optical department on a consultant and expense account basis. I left Tappins for my present office when the legislature of New Jersey said "that if and when I closed the optical department at Tappins no other optometrist

would be allowed to practice at that location." Tappins gave me a radio as a present for my new office, however, no official ever stopped in to wish me good luck even though it is less than a block from their jewelry store. I continued to act as a consultant to their Philadelphia optical department for two years.

I am sure you are wondering how and why I got so involved in this story of business intrigue, and to my regret I too cannot believe that I spent twenty productive years in this environment. My explanation is as follows: At the time I accepted the position, a war was in progress and I was subject to the draft. As a family man I was deferred. The company was paying me a decent wage by increasing prices profits increased and I was making more money than my optometric friends in their own private practices. I had a fear of opening my own practice because of the start-up costs and the competition of existent commercial offices and their high power advertising, which I was so well acquainted with. I was very naive and putty in the hands of profit minded corporate executives.

Since leaving Tappins ten years ago, I have become a respected practitioner among my peers and in Camden County. I now have the motivation to continually expand my education by attending lectures and study seminars. I had to provide a better service to my patients because I was no longer dependent on the power of advertising to get my patients. With the equipment supplied by Tappins and the time allowed each patient, I must confess, it was minimal eye care. At my office today, I spend approximately 45 minutes to one hour with each patient. Among the additional tests I perform are: Tonometry (measurement of pressure in the eye) slit-lamp examination (examination of cornea under high magnification) sphygmomanometry (blood pressure) detailed vision field studies and transillumination of sinuses -- tests of which I never performed at Tappins.

I am now actively involved in the optometric clinic of Camden and have given my time in visual screening programs for the community -- activities I never engaged in while employed in a commercial environment.

I do not believe that silence is golden and justice will triumph ultimately -- I have described my experiences to make this Committee aware that retail corporations are only concerned with profits and will find a way to make them -- at anyones expense.

Passage of ASSEMBLY BILL 3263 is not in the best interest of the public -- it would increase the price paid for glasses and lower the quality of eye care the citizens of New Jersey now receive.

Meyer Burt, O.D.

NEW JERSEY ACADEMY OF OPTOMETRY

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Reply to:

May 30, 1975

Assemblyman Byron M. Baer
Chairman
Commerce, Industry and Professions
Committee
35 Liberty Road
Bergenfield, New Jersey 07631

Dear Mr. Baer,

In view of the fact that we were unable to present verbal testimony before your Committee, due to poor scheduling, we are submitting for the official record the statement of our Academy on Assembly Bill 3263. To our knowledge, we are one of over 25 organizations and individuals who were not given the opportunity to verbally testify before your Committee. This is truly an unfortunate situation and certainly in my opinion does not satisfy the requirements for a Public Hearing. In my opinion the question and answer session, which normally follows the reading of a prepared text, is probably the most important part of any public hearing.

In view of the gravity of this issue and the affect it will have on the consumers of the State, we firmly believe that additional hearings are a necessity. A significant number of us were not given the opportunity to present our views to your Committee and it is highly unlikely that each Committee member will wade through the voluminous text of the proceedings in order to make an intelligent judgement.

Sincerely,

Ira Vineburg, O.D.
President

IV:rjk

cc: Members of the Commerce, Industry and Professions Committee, Mr. Joseph Capalbo
enclosure

STATEMENT BY THE NEW JERSEY ACADEMY OF OPTOMETRY
IN OPPOSITION OF ASSEMBLY BILL 3263
Spokesman: Dr. Ira Vineburg, President

I am Dr. Ira Vineburg, President of the New Jersey Academy of Optometry. The New Jersey Academy of Optometry is an organization dedicated to academic research and advanced clinical knowledge to the practice of optometry. We are associated with the American Academy of Optometry and the New Jersey Academy of Science.

We are to optometry what the Academy of Ophthalmology is to medicine. To belong to the New Jersey Academy of Optometry, the member must practice his profession on the highest professional level and adhere to a strict code of ethics and be recommended by his peers. He must present for review by the Academy Board, ten original technical research documents, relating to the profession of optometry and take an oral and written examination given by the American Academy of Optometry. Upon completion, he is considered for membership in the New Jersey Academy.

The Academy wishes to support the positions of other health care professional associations in their opposition to Assembly Bill 3263, which would permit full scale advertising of optometric fees and services and permit optometrists to be employed within retail establishments and by non-optometric corporations, individual opticians and any other lay person.

We can not condone this commercial attempt, cloaked in the guise of consumer interest, to bring our profession back to the mid-nineteen thirties when large commercial enterprises dictate the level of professional care being rendered to the citizens of this State. Professional health care responsibility to the pa-

tient will diminish as the pressure for speed and volume increases.

Rules governing health practices do not allow advertising which utilizes the appeals of the market place. People seeking services of the physician -- dentist -- or the optometrist, do so on the basis of professional reputation and of integrity and competence. For the unscrupulous or the incompetent to attract patients through advertising claims of being superior or of offering better services than another or at prices or on terms more favorable than another would not be in the best interest of the public's health. We therefore have laws and rules and regulations which have been sustained by the courts of the land to prevent advertising by those licensed in the healing arts.

The advertising of professional services tends to promote an unsafe climate of competition against those skilled in the profession. The "barker" and others who make their livelihood from human gullibility should not be allowed to apply their talents to human eyesight without serious consequences. An unsuspecting public is lead to believe that the store with the largest advertisements is the best to provide optometric services and the ophthalmic prescriptions which result from these services.

Promotional claims and price competition of eye glasses and contact lenses by ordinary advertising relegates these health appliances, which are available to the public only by prescription, to the ways of the market place and reduces the quality of eye care to the New Jersey consumer. Price advertising and claims of superiority may be proper for merchandise of the market place where people can make their own judgement, but people CAN NOT safely judge fraudulent, deceptive and misleading solicitations and ad-

vertising dealings with professional services and materials for eye care.

There is no question in the mind of the Academy members that this attempt to commercialize delivery of eye care to the citizens of New Jersey is being covertly orchestrated by large commercial interests that are more concerned with a fast buck than quality eye care. This Committee does not have to be told that the poor, uneducated and the elderly are open prey for unethical charlatons who lure them with advertisements and seem to have no compunction in taking advantage of their personal situation to make a quick profit. It is interesting to note at this point that while virtually every ophthalmologist, optometrist and guild optician provide services for Medicaid recipients at the established lower than average fee -- the large commercial chain operations refuse to service Medicaid recipients in many instances. This to me, personally, exemplifies their attitude toward the quick buck concept, with little regard for those citizens in a lower socio-economic strata.

The New Jersey Academy of Optometry pleads that you consider this legislation very carefully and its adverse effect on the New Jersey consumer and not vote this destructive piece of legislation out of your Committee.

I sincerely thank you for the opportunity of presenting this statement to you.

# # # # # # # # # # # # # # # # # #

New Jersey Pharmaceutical Association

Dedicated To Public Service Through Pharmacy Since 1870

118 WEST STATE STREET TRENTON, NEW JERSEY 08608

PHONE: 394-5596 AREA CODE 609

June 5, 1975

The Honorable Byron M. Baer
420 Lantana Avenue
Englewood, New Jersey 07631

Dear Mr. Baer:

Pursuant to your statement at the hearing allowing for rebuttal, we would like to specifically reply to the Federal Trade Commission's statements. The New Jersey Pharmaceutical Association would like to respond to the recent publicity given to the Federal Trade Commission's staff study on prescription drugs and the Federal Trade Commission's decision to preempt state laws as pertaining to prescription advertising.

It is the Federal Trade Commission's intention to invalidate all state laws that prohibit pharmacists from advertising the price of prescription drugs. As stated earlier in testimony given before this committee, we believe there would be little or no money savings to the consumer as alleged by the Federal Trade Commission and the New Jersey Division of Consumer Affairs.

It is our judgment that following a possible initial reduction in prices, the final result would be increased prices in order to absorb the cost of advertising. Because independent pharmacies do not have the capital to expend on advertising as do large corporations, many will be forced out of business leaving only a few very large giants. Once this occurs, these few would be free to charge any price they desire without fear of competitive pressure. This is similar to what occurred in the food industry with the advent of large supermarkets.

Additionally, the Federal Trade Commission's study refutes their own arguments by proving that prescription prices are not lower where advertising is permitted. By their own admission the argument that advertising would reduce prices is negated. It is our judgment that several things would happen if advertising were permitted. By allowing advertising and permitting its availability to large corporations, the danger of its predatory use exists.

This negative use of advertising would result in a decrease in the number of pharmacies. The decrease in individual service combined with the reduction in the number of pharmacies would result in a general decrease in pharmaceutical service throughout the state.

A major portion of the Commission's study addressed itself to an alleged conspiracy between associations which resulted in a restriction of price disclosure. While the Federal Trade Commission throughout their press releases has claimed the existence of a conspiracy, they have been unable to prove anywhere in their 694 page staff study that one actually does exist. While they admit that prices have not decreased where advertising is permitted, they continue to press for prescription price advertising. They have used this alleged conspiracy as an excuse for promulgating an unnecessary rule. We would like to say that this rule is unnecessary and undesirable because it would not achieve the Federal Trade Commission's aim of lower prices by their own admission.

Our Association contributed opinions to the Federal Trade Commission during the course of their study. Other state associations and national associations were asked to do the same. Their expertise, if any, is based merely on the interpretation of opinions which they sought from us as well as others. The conclusions drawn are therefore doubtful.

The Association has offered alternatives to the proposed advertising repeal which in our judgment offer a positive improvement to the delivery of health care and would not have a negative effect of advertising.

Respectfully yours,

Dorothy S. O'Connor, R.P.
Research Associate

DSO'C/mgp
cc: Members of the Assembly Commerce, Industry and Professions Committee

New Jersey Pharmaceutical Association

Dedicated To Public Service Through Pharmacy Since 1870

118 WEST STATE STREET TRENTON, NEW JERSEY 08608

PHONE: 394-5596 AREA CODE 609

June 5, 1975

The Honorable Byron M. Baer
420 Lantana Avenue
Englewood, New Jersey 07631

Dear Mr. Baer;

Subsequent to our testimony at the hearing May 22nd and 23rd on A1228 and A3273, members of the committee--as well as yourself-- expressed interest in certain areas, especially of Peer Review and suggested we submit to you prior to the close of the record more detailed information. We will try to include in this letter all areas which were of apparent concern or interest to your committee.

It had been mentioned by various committee members that while in fact advertising may not be the solution to the present problem, there are certain areas of abuse. A viable Peer Review Program was suggested as one possible method of eliminating or curtailing these abuses. As we indicated we had tried to work previously with government officials to get a state sanctioned Peer Review Program. We were unsuccessful at that time

We continue to feel that a Peer Review Program is probably the best method of preventing abuses. A Peer Review Committee is operative in the Medicaid Program, and has proven successful. It has led in many cases not only to the curtailment of abuses in the pharmaceutical area, but also to better service in this area. It is our judgment that the best qualified agency to conduct and administer a Peer Review Program is the Board of Pharmacy. Since they have the ultimate power of revoking a pharmacy permit or a pharmacist's license, they wield an authority that an association cannot. They also would have legal sanction.

It is our suggestion that a pharmacy when renewing his license would be required to submit on the renewal application data concerning his pricing structure. The pharmacy can choose any method of pricing he desires, but which

must be recorded with the Board of Pharmacy. Where prices deviate from his normal method, they too must be listed on the application. Changes in pricing structure could be made during the year, but the pharmacy would be required to file a letter or a form with the Board of Pharmacy indicating what changes are to be made twenty (20) days prior to the implementation of these changes.

The Board of Pharmacy would have the authority to review predatory and unconscionable prices. A council of peers and consumers acting on behalf of the Board of Pharmacy would serve as an initial review board. This board would be made up of seven members consisting of three representatives from Pharmacy (one to be appointed by the Board and two members to be appointed by the New Jersey Pharmaceutical Association); one Pharmacy member of the Board of Pharmacy chosen by the Board who would serve as chairman of the council, one economist familiar with the Profession of Pharmacy and appointed by the Board of Pharmacy and two lay people appointed by the Division of Consumer Affairs. The Board of Pharmacy could also consult other expert opinion as they see fit. Where there is a record of unnecessarily high prices or evidence that a pharmacy is using loss leader tactics, the Board of Pharmacy would have the power to take remedial action. This would be in the form of hearings, fines, suspension or revocation of license depending upon the extent of the seriousness of the charge.

It was also suggested that while pharmacists normally record prices either on record cards or the prescriptions themselves there is no Board of Pharmacy means of gaining access to these prices. It was suggested that a method of assuring a continuity existed. While this under normal conditions does exist, it might be feasible to require a pharmacist by law to record the price charged on each prescription or patient record cards.

The Association is looking forward to continued dialogue with the committee and the administration in order to seek a viable solution to the present problem.

Respectfully yours,

Dorothy S. O'Connor, R.P.
Research Associate

DSO'C/mgp
cc: Members of the Assembly Commerce, Industry and Professions Committee

News
from New Jersey Pharmaceutical Association
Dedicated To Public Service Through Pharmacy Since 1870

For Further Information Contact –
ALVIN N. GESER

118 WEST STATE STREET TRENTON, NEW JERSEY 08608
PHONE: 394-5596 AREA CODE 609

Trenton, June 4.

In response to the recent Federal Trade Commission move to invalidate state laws that prohibit pharmacists from advertising the price of prescription drugs, the New Jersey Pharmaceutical Association has stated that there would be little or no dollar saving to the consumer as alleged by the FTC. Alexander Bell, Association President, stated,

"In fact, while there may be an initial reduction in prices, the final result would be an increase in order to absorb the cost of advertising." Bell further stated,

""Independent pharmacies do not have the capital to expend on advertising as do large corporations. Because of this, many will be forced out of business, leaving only a few very large giants. Once this occurs, these few would be free to charge any price they want, without any competitive pressure. This is similar to what happened in the food industry with the advent of large supermarkets." Bell said,

"The FTC study proves that prescription prices are not lower where advertising is permitted.

"Their own study negates the argument that the advertising of prescription prices would decrease price.

"What does happen is the availability of advertising, and its predatory use would result in a decrease in service as well as a decrease in the number of pharmacies. These two things in combination would cause a general decrease in pharmaceutical services throughout the state."

STATEMENT BY NORMAN E. WALLIS, Ph.D., O.D.
PRESIDENT, PENNSYLVANIA COLLEGE OF OPTOMETRY
RELATING TO ASSEMBLY BILL 3263

Newark, New Jersey

May 22, 1975

Mr. Chairman,

My name is Norman Edward Wallis, and I am the President of the Pennsylvania College of Optometry, Philadelphia, Pennsylvania. I am also the Vice President of the Association of Schools and Colleges of Optometry, the official association of the thirteen colleges of optometry in the United States, the two colleges of optometry in Canada, and several colleges of optometry in South America.

I graduated from the optometry program of The City University, London. I hold a Master's degree in Physiology, and a Doctor of Philosophy degree in Physiological Optics from Indiana University, Indiana. I have served as Assistant Dean of the University of Houston, College of Optometry; Director of the Division of Special Studies at the Massachusetts College of Optometry; and I assumed the presidency of the Pennsylvania College of Optometry in September 1972. Among other responsibilities, I am the Chairman of the Council on Clinical Optometric Care of the American Optometric Association, the official accrediting body of the profession for institutional optometric eye care.

My reason for testifying today is to present a perspective of optometry, from the academic and educational base, which is very relevant to your decisions on Assembly Bill 3263. I will not discuss the philosophical and professional effects should Assembly Bill 3263 be passed. However, I sincerely feel that

a better understanding of the education of optometrists, and their role as primary health professionals, should be placed before you so that your decisions can be made based on a complete understanding of this profession.

Although the profession legislatively is relatively young, the optometry act in New Jersey having been passed in 1914 , many of the basic concepts, and many of the inventions and discoveries that are still the foundation of much of what the optometrist does, go back several thousand years. All of the scientific information that relates to other health professions such as medicine, dentistry, podiatry are also considered fundamental knowledge to optometry. In addition, the specific background information in the areas of visual science and optics pre-date the birth of the profession of optometry as an independent unit by several hundred years. Thus, the profession can trace its heritage well before its formation as a profession, and also clearly distinct from the development of other health professions, such as medicine.

At the turn of the century, optometric education was in the same confused state as medical education. The Flexner Report of 1910 had a major impact on medical education, and set a pattern of development that would hold for the next half a century. At that time, medical education was varied, and a lack of consistency existed throughout the country; remarkable considering the fact that medicine as a profession had already been identified for many centuries. Optometry, a newly identified profession receiving legal recognition by the State of New Jersey in 1914 , set about improving its educational base. The College I represent here today, the Pennsylvania College of Optometry, was founded in 1919 on the same model as the independent health professional schools in Philadelphia. Even then, the program was restricted to graduates of accredited high schools and was two years of full-time study. In 1923,

the College granted the first Doctor of Optometry degree in the world and since that point has been a leader in all aspects of education. More than twenty years ago, the College established a minimum curriculum of two-years of college preparation followed by four-years of professional education, the same standards that existed for other health professions such as dentistry. This is significant because most of the optometrists practicing in New Jersey today graduated within this time span. Consequently, the average practitioner in New Jersey has received an educational program of equal length to his colleagues in dentistry and medicine.

Also important is the fact that 63% of the optometrists in New Jersey are graduates of the Pennsylvania College of Optometry. The College has been the major resource for the development of optometric manpower in the State and continues to work very closely with the optometrists and the Department of Higher Education to assure a continual flow of well-educated and trained young doctors into New Jersey.

To assist in the development of this educational base, the Federal Government has recognized its responsibilities by including optometry in legislation supporting health profession's education. Thus, since the middle of the 1960's optometry has been receiving federal funds through the Health Professions Educational Assistance Acts along with its sister professions of medicine, dentistry, osteopathy, podiatry, pharmacy and veterinary medicine. Likewise, many states have recognized their responsibilities by providing significant state support to the optometric institutions, not only those schools located within state universities (such as the University of California at Berkeley, Indiana University, The Ohio State University, The State University of New York, University of Alabama in Birmingham), but also through contract programs with independent schools, such as my own.

Thus today, optometric education in terms of structure, quality, involvement with federal and state funding and all other aspects of its development is remarkably similar to all the other primary health professions.

Although what I will say next relates to my own institution, the same information is representative of all other twelve colleges in the United States.

For the entering class of 1974, 1,034 well qualified students applied to be admitted. One hundred and thirty-eight were selected. Of these 138, 92% already held a baccalaureate degree in a science (60% in the biological sciences), and the other 8% had a minimum of three years of college preparation. The minimum entrance requirement for the Pennsylvania College of Optometry is 90 hours of undergraduate preparation, including very specific requirements in the core subjects of mathematics, physics, chemistry (including organic), biological sciences, microbiology, and psychology.

The students then undertake a vigorous four year professional program. This program is approximately equally divided between the teaching of basic and professional studies in didactic and laboratory settings, and experience in the many and varied patient care facilities of the College.

In the first professional year, the emphasis is in the biological sciences (gross and microscopic anatomy, physiology, general pharmacology, genetics and developmental anatomy); basic optics (geometric and ophthalmic); visual sciences (physiological optics and visual psychophysics); and in health care delivery and general optometry. In this year a student undertakes a total of 880 clock hours of instruction.

In the second professional year, biological sciences emphasize ocular biology and ocular pharmacology, and the emphasis in the areas of visual sciences,

relates specifically to optics and ophthalmic optics, the study of physiological optics, and strong areas of the professional program in the examination of the patient, diagnosis and treatment of conditions of the vision system and general pathology and diseases of the eye. Introductory work in the specialty areas of contact lens practice, vision rehabilitation, pediatric optometry are begun. During both years, the student experiences involvement in patient care in the College clinics. Working with fourth professional year students and faculty, he acts as an observer and assistant, utilizing his rapidly developing knowledge and skills under very close supervision in an appropriate teaching situation. In this year, a total of 1100 hours of instruction is given.

The third professional year truly expands on the base of understanding and knowledge developed in the classroom and laboratory by increasing significantly the patient care exposure. In this year, the student assumes more responsibility for the examination of the patient especially in the areas of general optometric care. In addition to his clinical work classroom educating includes vegetative physiology of the eye, pediatric optometry, vision rehabilitation, contact lenses, public health issues, interdisciplinary health care, and diseases of the eye. This year has over 1100 hours of instruction.

In the fourth professional year, the emphasis is primarily patient care, with increased opportunities for external rotations from the College, and elective courses relating to specialty areas of the profession. Selected students have experiences at St. Christopher's Hospital for Children (pediatric ophthalmology), at the Center for the Blind in Philadelphia (vision rehabilitation), at the Camden Optometric Eye Clinic, at the Maryland Optometric Center, at the Joseph C. Wilson Health Center in Rochester, New York, at the Riverview Home for the Aged (geriatric care), at the Philadelphia Prison System, and in private practice. By an innovative program, students are able to be rotated

through private offices as part of their educational experience, under very careful supervision and control by the College. Also in this year, students experience rotation through an interdisciplinary team health delivery system with fourth year students of medicine (Hahnemann Medical College), dentistry (University of Pennsylvania), podiatry (Pennsylvania College of Podiatric Medicine), clinical pharmacy (Philadelphia College of Pharmacy and Science), graduate nursing and social work (University of Pennsylvania). This program is federally funded and is known as the Philadelphia Interdisciplinary Health and Education Program. Thus, not only the student is thoroughly educated and trained in primary eye care, but also is being increasingly exposed to the health care issues of the day and the various ways of providing health care through an evolving health delivery system. This year has 1200 hrs. of instruction.

In addition to the program briefly outlined above leading to the Doctor of Optometry Degree, the College's Division of Continuing and Post-Graduate Education has responsibility, and acts as a resource, for the continuing competency of the optometrists in the State of New Jersey. Already, the College has developed programs in conjunction with the New Jersey Optometric Association in areas of pharmacology, and is working with local societies to develop programs to be presented by the College with outstanding educators from optometry and other disciplines, in the local areas where optometrists practice. This outreach program is consistent with the aims of the profession in New Jersey by the recent enactment of a continuing education requirement for all practitioners. Thus, the profession in New Jersey intends to police itself through continuing education and indicates its commitment to maintain the competency of its practitioners to provide high quality eye care. The College recognizes its responsibilities and is working with the profession to develop these opportunities. In the year 1974/75, over 880 optometrists will have attended continuing education courses offered by the

College in many different locations, including New Jersey.

In addition to three major clinical facilities in different locations in Philadelphia, the College has its 13 acre main campus in North Philadelphia, on which is located a main educational building completed in 1970 with funds from the Department of Health, Education and Welfare and the General State Authority of Pennsylvania. Presently under consideration by the Department of Health, Education and Welfare is a construction grant request of 4.9 million dollars for the establishment of a new on-campus major teaching clinical facility to be integrated into the main building. The College is committed to improving its facilities to further enhance the quality of education of all its students, including those residents in New Jersey.

The faculty of the College is composed of 53 full-time equivalent members. This is represented by 67 educators, 34 of which are full-time. Most of the part-time faculty members (at least 50% teaching responsibilities) are practicing optometrists instructing students in the areas of patient care. Many of these faculty members also practice in the State of New Jersey. Included in the faculty are O.D.'s; Ph.D.'s in basic sciences (development biology and genetics, physiology, pharmacology, physiological optics, physics, psychology); O.D. plus Ph.D's; M.D.'s; other specialists including attorneys and accountants. Standards of selection of the faculty are extremely high and the College has always attracted to its teaching programs the very best talent from around the country.

Mr. Chairman, the scope and quality of optometric education today is comparable to its sister health professions. The same type of student is selected for education in its programs, and through increasing integration of education with other disciplines, such as the Philadelphia Interdisciplinary Health and Education Program, the optometrist recognizes his or her role as a health professional, with the primary focus of practice being primary eye

care.

Because of this educational base, your deliberations on Assembly Bill 3263 should not ignore the fact that optometry is a health profession. Although its antecedents relate very strongly to disciplines having primary concern with materials related to eye care, it is a fact that the professional education of optometrists has been, and always will be, service oriented, not oriented to the sale of ophthalmic materials.

Mr. Chairman, if there are any questions I will be happy to answer them from the perspective of an optometric educator.

Respectfully submitted,

Norman E. Wallis, Ph.D., O.D.
President

NEW/ehc

GLENWALL PHARMACY INC.
2805 BELMAR BOULEVARD WALL, N. J. 07719
PRESCRIPTIONS - DRUGS - COSMETICS
HALLMARK CARDS - GIFTS

The present distribution of prescription medication through community pharmacies provides a broad selection of quality medication and intimate professional service at a reasonably low cost. Community pharmacies are convenient for easy access by foot or auto without long trips to regional shopping centers. This is a significant saving in time, energy and dollars.

Prescription price advertising would be subject to the same abuses that we find in grocery and sundry advertising, namely, loss leaders, bait advertising, misrepresentation. However, pharmacy is not grocery-it is a professional health service requiring professional skills of interpretation, selection, communication between patient and pharmacist-physician and pharmacist, all for the benefit of the public.

Prescription price advertising would create market place chaos and a proliferation of low quality brands of medicine in order to turn a profit at unrealistically low prices. The ultimate consumer would get lower quality products and less professional service, if any, as cost cutting will create pressure to eliminate professional service and lower quality standards. The present system allows competition for quality and professional services at reasonable prices. The market place now ranges from discount store pharmacy departments to community pharmacies with more services-the consumer may choose.

There is no justification to interfere with a professional service now functioning for the benefit of all concerned. Government bureau statistics have shown pharmacy prices to have risen the least of any health service. Prescription price advertising should not be permitted to undermine our present high quality of pharmaceutical service at reasonable prices.

The Honorable Byron M. Baer, Chairman
Assembly Committee On Commerce, Industry, & Professions
420 Lantana Avenue
Englewood, New Jersey 07631

FOR THE RECORD PUBLIC HEARING ON PRESCRIPTION PRICE ADVERTISING BILL NUMBER A-3273 PUBLIC HEARING

Thursday, May 22, 1975
Seaton Hall University School of Law
Room 117
Newark, New Jersey

I, Brian H. Miller, President of Somerset-Hunterdon County Pharmaceutical Association, wish to present the views of our county pharmaceutical association which represents over 100 practicing pharmacists from all phases of pharmacy over a three-county area. I wish to present the views of these pharmacists with respect to the prescription advertising bill, which is the topic of this hearing. The prescription advertising bill basically pertains to the practicing retail pharmacist, and I am going to be expressing their viewpoints at this time.

The retail pharmacist is a very unique, professional person. He offers a very valuable professional service, and yet at the same time, he is selling a commodity. Let me at this time describe to you gentlemen the processes that go into the actual physical compounding of a prescription and the rendering of that prescription to the patient, using as illustrations the time involved in preparing the prescription, as well as the time involved in instructing the patient in the correct usage of the particular medication.

When a patient presents a new prescription, the pharmacist turns to the patient's profile card before actually compounding the prescription. The patient's profile card has many valuable functions:

1. It gives a complete history of all members of a particular family.
2. It gives the ages of the members of the family.

3. It tells the pharmacist if any members of the family are allergic to any medications.
4. It allows the pharmacist to see if the particular patient is taking any other medication at this time which might conflict with the new prescription being filled presently.

These services are extremely valuable, and later I will demonstrate a few examples of how the use of the patient profile card can not only prevent the occurrence of allergic reactions but prevent duplication of medications. One criticism that has arisen is that the patient profile cards force a patient to shop in a particular pharmacy. Yes, this is true, but a patient should select a pharmacist with the same care that he would select a physician. It is very important for a patient to use one pharmacist and only one pharmacist for the reasons I previously stated. For example, if patient A is going to four different pharmacies, the various pharmacists have no idea what other medications patient A may be taking at this time, and serious consequences may follow. Thus, if a patient utilizes a single pharmacist, he can render a very important service with the use of patient profiles. Once the pharmacist has scanned the patient profile, made sure the patient is not allergic to the new prescription, and is not taking any other medication that will interfere with the new prescription, he proceeds with compounding of the prescription.

Today it is true that most medications are already made before they reach the pharmacy, but on the other hand, the drugs are more potent pharmacologic agents than those used years ago when pharmacists practiced the art of compounding. The pharmacist must know all the side effects of these drugs and the possible drug interactions which might occur. When a typical patient says, "Well, you are <u>just</u> taking tablets from one bottle and putting them into another," this is not true. This is what the patient is seeing, but this is the least important part of filling that prescription. Once the pharmacist has completed the physical part of filling the prescription, another vital professional service of the pharmacist is rendered. The pharmacist at this time must instruct the patient in the exact manner that

the prescription is to be taken and assist the patient in obtaining optimum effectiveness of the drug. For example, there are many drugs that are to be taken with food and many drugs to be taken without food. In my specific practice of pharmacy, I keep a documented record showing the incidence of patients who do not fully understand the directions that were given by the physician. In many cases, the physician is relying on the pharmacist to explicitly explain the complete directions on the prescription. A typical example one might use is a prescription for tetracycline, which is a broad spectrum antibiotic used for many different types of infections. The physician's directions for dosage might read, "one capsule four times a day." It is the duty of the pharmacist to inform the patient that the directions mean, "one capsule four times a day either an hour before or two hours after meals," and that no dairy products should be taken in that interval because both food and dairy products would drastically interfere with the absorption of this drug. Statistics in my particular pharmacy show that very few physicians have explained this total concept of directions because the doctor knows that I, as a pharmacist, am going to explain these directions. Now as you can see, filling a prescription is really broken down into three phases:

1. The use of the patient profile system.
2. The actual physical filling of the prescription.
3. Instructing by the pharmacist to the patient of the proper instructions on the prescription.

In the event that advertising of prescription medications become prevalent, some of these functions of the pharmacist will be lost. The pharmacist will be forced to reduce the cost of the prescription to the patient, which will necessitate a reduction in professional services. I, for one, surely would not want to see the use of the patient profile system go by the wayside or the personal consultation on the directions to the patient go by the wayside for the sake of allowing a patient to save a few cents on the prescription.

I would now like to give an example of how the patient profile card in my pharmacy recently prevented an allergic reaction. By the use of the patient profile card in the filling of a recent prescription, I initially detected that the patient had a previous allergic reaction to penicillin. The prescription was for a semi-synthetic penicillin. I questioned the patient as to whether she had informed the physician that she was allergic to penicillin, and she replied, "Yes, but he told me to take the prescription anyway." Using my professional judgement, I called the physician, explained to him that this specific person had a severe allergic reaction previously to penicillin, and asked him if he was aware of this history. The physician said he was aware of her history, but in our further discussion, he told me he did not realize the severity of the penicillin reaction she had in the past. Upon my suggestion, the physician then changed the prescription to a non-penicillin antibiotic. This action prevented a possible reoccurrence of a severe penicillin reaction.

I would like to give a second example of how the patient profile system in my pharmacy prevented a duplication of medication that would have been dispensed to the patient if she had used more than one pharmacy. A hypertensive patient's regular physician was on vacation and the lady went to the covering physician. She was taking a diuretic in conjunction with an antihypertensive drug for her blood pressure. The drugs were not properly regulating her blood pressure, and the covering physician prescribed two additional drugs, not knowing the previous drugs the patient had been taking. When the patient handed me the new prescriptions, I immediately used the patient profile card and discovered the duplication of medication. I called the covering physician and gave him this very important information of which he was not aware. He then told me to cancel one of the new prescriptions he had just given the patient and to have her continue taking the old medication with addition of just one of the new prescriptions. If the patient had been shopping for the lowest priced prescriptions and had taken these new prescriptions to another pharmacy, this duplication of medication would not have been detected, and very possibly the combination of all these medications would have been detrimental to the patient's health.

We, as pharmacists, hope that all of you committee members will truly consider the valuable professional services that a pharmacist renders the public in the filling and the pricing of prescriptions. We believe that price advertising will do nothing more than confuse the public and force the pharmacist to treat prescriptions strictly as a commodity and reduce the pharmacist's professional services rendered.

As our legislators, you are charged with the obligation of protecting the consumer's health and welfare. The consumer movement, through this proposed prescription advertising bill, is attempting to expedite a small financial benefit for the public at the cost of the public's health and welfare.

Brian H. Miller RP
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