HEARING AIDS AND THE OLDER AMERICAN

HEARINGS

BEFORE THE

SUBCOMMITTEE ON CONSUMER INTERESTS OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-THIRD CONGRESS

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HEARING AIDS AND THE OLDER AMERICAN

MONDAY, SEPTEMBER 10, 1973

U.S. SENATE,
SUBCOMMITTEE ON CONSUMER INTERESTS OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2 p.m., in room 1318, Dirksen Office Building, Hon. Frank Church, chairman, presiding.

Present: Senators Church and Fong.

Also present: William E. Oriol, staff director; Patricia Callahan, professional staff member; John Guy Miller, minority staff director; Robert M. M. Seto, minority counsel; Margaret S. Faye, minority professional staff member; Patricia Oriol, chief clerk; Gerald Strickler, printing assistant; and Ann Todaro, clerk.

OPENING STATEMENT BY SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. The hearing will please come to order.

My comments will be brief because our witnesses have a great deal to tell us on a matter of considerable importance to many older Americans.

Congress, from time to time, increases Social Security and takes other actions to improve retirement income. But it seems to me that Congress should also take notice of consumer issues that may have great economic and emotional impact upon the elderly.

For that reason, the committee will turn its attention during the next 2 days to the very real problems encountered by older persons with hearing loss. Many of them could benefit from hearing aids, but many do without these devices because they cannot afford to pay out sums ranging anywhere from $100 to several hundred dollars.

Some help is available from Medicaid, but the policies vary widely from State to State. Some help is available through efforts of the industry and individuals to provide help in special cases, but here again such assistance is far from universal.

It is only natural, therefore, to ask whether the time has come for Medicare to cover hearing aids and possibly some additional forms of treatment needed by aged and aging persons who suffer from hearing impairment.

There is no doubt in my mind that few disabilities have more harsh impact upon the elderly. Physicians and others have told this committee that many elderly individuals suffer severe psychological damage when their hearing fails, partially because of reluctance to face up to the problem and partially because the loss takes place so gradually that it may be unnoticed. In any case, the problem soon becomes one of emotional isolation as well as hearing deficiency.

Why, then, should Medicare not be called in to help? A few years ago, when this committee first explored hearing aid issues, I felt that there might be some reluctance to include hearing aids under Medicare because they are an expensive item and because there could be administrative problems.

Medicare Coverage of Hearing Aids

That feeling now seems to be changing. A few weeks ago, for example, former Health, Education, and Welfare Secretary Wilbur Cohen told this committee that in 1965 he had opposed Medicare coverage of hearing aids because he felt that Medicare could do only so much in its early years. But, he now feels that it would be feasible to do so. Furthermore, he believes that a very simple deductible, such as 20 percent of the cost of the hearing aid, could keep administrative difficulties to a minimum.

Dr. Cohen's opinion merits close attention by this committee, and I will ask for comments on his position during these hearings. In addition, I will seek views on other issues, such as:

—How many older persons in need of hearing aids are now denied them?

—According to the Federal Trade Commission, the average price of a hearing aid to a dealer is about $100, but the average retail price to the hearing handicapped is about $350. Industry spokesman say that markups may seem high, but that hearing aid dealers perform many services before and after the sale. This raises a question: Would standards of service have to be written into any law providing Medicare coverage of hearing aids?

—The industry also says that their total sales are small, averaging about $60 million—but the Federal Trade Commission says that the retail price total exceeded about $175 million.

In any case, the question remains: How much larger can and should the hearing aid market be, especially if given new incentive by widening Medicare to include such devices?

—What kind of protection against abuse should be written into any new law? We have seen, since 1966, some profiteering under Medicare and Medicaid. New York City newspapers told earlier this year of persons receiving hearing aids in nursing homes even though they did not need them.

I have received a letter from a Rhode Island physician who warns against the possibility of widespread abuses unless strict rules are laid down as to procurement of hearing aids. He says, for example, that hearing aids for persons with otosclerosis will not help the patient and in some cases may even delay proper treatment of the hearing loss for several years.

Potential Cost of Coverage

I have other questions, but I will close by commenting on the potential cost of Medicare coverage of hearing aids. The Special Committee on Aging has received estimates of $300 million for the first fiscal year and $200 million for the second, based upon the following assumptions:

(1) That hearing aids would be available only when prescribed by a doctor.

(2) That a fee schedule would be set up to limit costs to a reasonable level when compared to manufacturing costs.

(3) That a $60 deductible and 20 percent coinsurance charge be made.

(4) That the $60 deductible for a hearing aid would also satisfy the $60 deductible for other part B services.

Not everyone will agree with these conditions, I am sure. But I think they provide a good framework for discussion.

I will conclude by thanking our witnesses for the help they have already provided in preparation for this hearing. Mr. Nader and the Retired Professional Action Group have been generous in discussions of the points raised in their new report. I am glad to see that so many private citizens have given so much of their time to gather information on matters that may often be technical, but which can be of direct personal importance to individuals.

Representatives of the hearing aid industry have been equally helpful. They have spent many hours in discussion with committee staff here in Washington as well as at the offices of the Hearing Aid Society in Detroit. I am grateful for their help and for the considerable expertise they have shared.

Much the same can be said of one of our witnesses, Dr. Sullivan. He also served the committee in exploring technical matters within recent weeks, and we are grateful for his help.

We will begin the proceedings with a presentation by the Retired Professional Action Group.

I will ask Elma Griesel if the members, starting with Elma, might introduce themselves, and then we will proceed with a panel discussion.

STATEMENT OF RALPH NADER, CENTER FOR THE STUDY OF RESPONSIVE LAW, REPRESENTED BY ELMA GRIESEL, COORDINATOR, RETIRED PROFESSIONAL ACTION GROUP; MRS. BETTY HAMBURGER, BALTIMORE, MD.; FRANK P. DICKEY, ESQ., ARLINGTON, VA.; WENDY WILSON, WASHINGTON, D.C.; MRS. ANGELA LOAVENBRUCK, SPRINGFIELD, VA.; IDA KLOZE, WASHINGTON, D.C.; AND MRS. BARBARA HOGAN, WASHINGTON, D.C.

Miss GRIESEL. My name is Elma Griesel. For the past 2 years I have been coordinator of the Retired Professional Action Group which is sponsored by Ralph Nader under his Public Citizen, Inc.

I have with me member staff associates of the Retired Professional Action Group.

We come from varied backgrounds, legal profession, teaching, audiology, economics, and so forth.

My particular background is in public health. I received a master's degree in public health in 1968 from the University of Oklahoma, where I specialized in gerontology.

After that time, I was employed by the Oklahoma State Health Department as a consultant in gerontology and after that served as health consultant for the National Council on the Aging.

We will start at the end of the table with Barbara Hogan who will introduce herself.

Mrs. HOGAN. I am Mrs. Raymond Hogan, I am a retired science teacher from Trinity College in Washington.

I was in the biology department when I retired last year.

I was assistant professor, and I have been working on the hearing disability study for the past year.

Mr. DICKEY. I am Frank P. Dickey, retired, former attorney of the U.S. Department of Agriculture.

I graduated from Oberlin College in Ohio, from law school at the University of Oklahoma, and I am a member of the Oklahoma bar and Florida bar.

In 1941 I went to work as an attorney with the Department of Agriculture where my work was almost entirely legal work for the Farmers Home Administration.

Presently I am employed as a volunteer with Ralph Nader's Retired Professional Action Group.

Senator CHURCH. Thank you.

Mrs. KLOZE. I am Ida Kloze, I am a lawyer, graduated from the University of Maryland Law School and got a B.A. at Georgetown University.

I was previously with the Federal Trade Commission as an antitrust trial attorney and as a general attorney with their Food and Drug Division.

I have been working with the Retired Professional Action Group for about a year.

Mrs. HAMBURGER. I am Mrs. Betty Hamburger of Baltimore, Md.

I served as vice president of Hamburger's, Inc., a department store, and was its publicity director for 27 years before my retirement a few years ago.

I am a graduate of Columbia University, and I have served as president of many organizations in Baltimore where I have been very active in community service.

Senator CHURCH. Thank you.

Mrs. LOAVENBRUCK. I am Dr. Angela Loavenbruck. I have both a masters and doctorate from Columbia University in speech pathology and audiology.

I worked 4 years at the Rockland Center in New York State where I was responsible for administering over 350 hearing aid evaluations each year.

At the present time I am assistant professor of audiology at Catholic University.

I have also worked as an audiology consultant.

Ms. WILSON. I am Wendy Wilson, I have a B.A. in economics from Wheaton College in Massachusetts.

Among my work experiences was serving as attorney placement director and administrative assistant at the D.C. Bar Association.

Senator CHURCH. Thank you very much, members of the panel.

Before you deliver your opening statement, I want to recognize Senator Fong, the ranking minority member of our committee for any preliminary remarks he might want to make.

Senator FONG. I have no preliminary remarks except to say I am pleased that you have called these hearings.

Senator CHURCH. Thank you very much.

Elma, will you please proceed with your statement.

STATEMENT OF ELMA L. GRIESEL

Miss GRIESEL. Thank you, Mr. Chairman.

The Retired Professional Action Group (RPAG), an organization funded by Public Citizen, Inc., has just completed a 15-month study of the hearing aid industry. A summary of the findings of that study is contained in their summary report which will be released this week.* During the course of the study, RPAG staff associates in Washington, D.C., and volunteers in four States had contacts with more than 1,000 persons—hard of hearing individuals, their families, medical ear specialists, audiologists, hearing aid dealers, manufacturers, and workers with the deaf and hard of hearing. RPAG also contacted more than 200 State, local, and Federal offices of Medicaid and Vocational Rehabilitation; State offices of the attorney general, consumer groups and agencies, and hearing aid dealer licensing boards.

Based on this extensive research, RPAG concludes that the hearing aid industry has failed to adequately furnish quality services, products, and information; that most older people have to depend entirely on commercial establishments for the diagnosis and treatment of hearing loss; and that neither Government agencies nor health professionals have yet come to grips with the problem.

RPAG further concluded that:

(1) The high profit, low sales volume hearing aid industry uses many of the business community's worst practices to sell hearing aids—practices totally unacceptable for any industry—let alone the health care industry.

(2) Government agencies, with the exception of the Veterans' Administration, either place the problems related to hearing impairment at the bottom of their priority list or show lackadaisical interest and flaccid performance in protecting the hearing impaired.

(3) College and university programs have promoted speech therapy at the expense of hearing therapy. They have failed to train and to motivate students of audiology toward providing services for older people and toward advocacy activities for the hearing impaired.

(4) Most medical students graduate with minimal training and little knowledge of hearing impairment or possibilities for its correction.

INEFFECTUAL COMMUNICATION

Each year many Americans withdraw from normal social interaction with others because of hearing disabilities. Many who become virtual recluses appear normal to the casual observer. Forced into life patterns completely alien to their previous behavior, the hard of hearing often become "human islands" to avoid frustrating, ineffectual communication with others.

Our society tends to put aside older people and to consider health problems associated with aging as low priority or unimportant. Hearing loss is generally considered a problem associated with growing old. Furthermore, because of the shortage of medical and clinical audiological resources and a dearth of public advocacy, the hearing

*See letter and summary report, appendix 1, item 2, p. 84.

impaired have been virtually handed over to a profit-motivated industry—the hearing aid industry—for care.

Senator CHURCH. Before we proceed, I think I should make an announcement that Mr. Nader was anticipated to have appeared, as he had been scheduled to appear. The panel of course is speaking on behalf of the Nader inquiry for this subject; however, owing to Dr. Kissinger's hearings, presently being conducted before the Foreign Relations Committee, it was necessary to make a time change on this hearing, and as a consequence, Ralph Nader will not be able to appear this afternoon.

I just thought the people who were here who might anticipate seeing or hearing Mr. Nader should know that, and the reason for the change.

Mrs. Kloze, please proceed with your statement.

STATEMENT OF MRS. IDA KLOZE

Mrs. KLOZE. Thank you, Mr. Chairman.

An example of the prevalence of hearing impairment in the United States is mentioned in the report of the subcommittee of human communication and its disorders, National Advisory Council of Neurological Diseases and Stroke (NIH), Bethesda, Md., prepared in 1969.

The report estimates that 15 million people have some degree of hearing loss. About one out of every 12 persons is affected, and medical help is needed by about 8½ million persons, probably 3 million of whom have major hearing defects. About 200,000 persons cannot hear even the loudest speech well enough to understand what is being said. These people are described as "deaf."

Advancing age is responsible for about 16 percent of all hearing loss.

More than 60 percent of retail sales of hearing aids to the public are the result of direct (and first) contact with hearing aid dealers. The remainder are referred to dealers by medical doctors or by hearing clinics.

SUMMARY POINTS

(1) People needing prosthetic leg and arm devices go to doctors who prescribe braces, crutches, or special supports. People seeking help with speech defects go to trained speech therapists and most people with visual handicaps go to medical eye specialists. Why do most people with hearing problems go to dealers rather than to medical ear specialists or audiologists? The main reason why consumers first turn to dealers is their accessibility. There are approximately 6,000 hearing aid dealerships in the United States. Approximately 15,000 dealers and salesmen are employed in these dealerships. These dealers are easily accessible to the consumer. They advertise in the yellow pages and in the newspapers, through direct mailings to the public, door to door selling, and their store front offices, they beckon those with hearing problems. On the other hand, medical specialists and audiologists are prohibited from advertising by their codes of ethics. They are few in number and are concentrated in medical centers and universities.

(2) Most consumers know next to nothing about who provides specialized care for ear problems and hearing loss. Approximately 70

percent of the purchasers of a hearing aid in 1972 consulted neither an otologist nor an audiology clinic. Hearing aid dealers appear to have successfully convinced the public that they are the primary providers of care.

(3) Since the aim of the hearing aid dealer is sales, he must get the consumers into his shop or get himself into their homes. In a marketing seminar at the 1972 annual NHAS meeting, direct mail was cited as the single most important resource—"particularly in light of the fact that more than half of the sales are replacement sales." One industry survey in 1968 estimated hearing aid sales in the home to be better than 60 percent of total sales. Several dealers reported to RPAG that as high as 80 percent of their sales are made in the homes of consumers. In many dealerships the dealers or their salesmen work primarily in the field—calling on people whose names they bought or were given. Most consumer complaints RPAG reviewed resulted from a home sale.

(4) Inadequate professional clearance before hearing aid fitting is one of the most serious abuses found in this study. General practitioners often do not know specifics about hearing impairment, hearing evaluations, and hearing aids. They often refer patients directly to hearing aid dealers instead of sending them to medical ear specialists or audiologists. As a result, consumers can be sold hearing aids when they actually need medical treatment, surgery, or special rehabilitative services.

(5) Although the industry claims its policy is to advise people to see a doctor, RPAG experiences reveal this seldom occurs, even when a dealer is asked explicitly, "Do you think I should see a doctor before I buy a hearing aid?" A Los Angeles RPAG volunteer called 86 dealerships and asked this question. Only 19 dealers said yes. When this question was asked by participants in a New York City survey, only 1 to 20 dealers suggested seeing a doctor first! Those dealers who do refer often have arrangements with general practitioners who generally do not have sufficient knowledge of the ear to make a thorough diagnosis. What is worse, these doctors usually end up referring the person back to the dealer instead of someone who can make a thorough diagnosis.

Inadequate Training of Dealers

Only 2,114 of approximately 15,000 hearing aid dealers and salesmen have received training to maintain standards of competency, education, ethics, and reliability. The 2,114 dealers are certified by their trade association, the National Hearing Aid Society, after they have completed the society's 20-week home study course. Professional analysis of the course shows that each of the chapters of the study said to require about a week for each chapter, presents material requiring a full semester course for university audiology students. The course has been rated as superficial with important factors oversimplified or not covered. Usually the examination is given at the annual NHAS convention—after a special cram review. It does not include any evaluation of the examinees practical skills in testing and fitting or any evaluation of the examiners ability to communicate and counsel with the hearing impaired.

Manufacturers offer even less training to the dealers they hire. Salesmen are hired to work on commission outside the office, so the little training they receive is focused on selling.

State licensing of hearing aid dealers eleminated some of the worst offenders and the most ignorant of the salesmen, but there is no indication that licensure has resulted in better trained dealers and salesmen.

Twenty-nine States issued licenses or certificates without examination to dealers and salesmen who had been in the business for 2 to 3 years before those States adopted hearing aid dispensers laws. Of these 29 States, only seven required any testing of dispensers after enactment of the law; and then dealers were allowed anywhere from 18 months to as much as 6 years (Connecticut) to pass the examination. A recent bill passed in Neveda "grandfathers in" anyone who has been engaged in the business for at least 90 days. These persons are issued licenses as "hearing aid specialists." It is apparent that thousands of dealers and salesmen became "licensed" overnight without minimal training.

As a result of all these problems, most hard of hearing consumers literally fend for themselves in a marketplace which too often runs counter to their interests. In an effort to depict what can happen to consumers, RPAG conducted its own field investigation of hearing aid dealer practices.

Senator CHURCH. Thank you for that excellent statement.

The next member of the panel, Mrs. Hamburger.

STATEMENT OF MRS. BETTY HAMBURGER

Mrs. HAMBURGER. Thank you, Mr. Chairman.

We conducted a study to try to get information on what happens to ordinary people when they go into hearing aid dealers.

The study was conducted by volunteers, six women and two men, all from aged 62 to 80.

We were briefed on the essentials of hearing impairment, and were given a list of questions to put to dealers which would bring out certain facts: Whether medical assistance was required; what type of testing was given; what type of hearing loss we had, and to what extent we had a loss; whether an aid was recommended or not; and whether after the aid was recommended, the dealer would recommend the patient to seek medical assistance; and, information about warranties, prices, and other such things.

I am only going to hit the highlights because of time.

The dealers were chosen at random from the inner city Baltimore area, instead of the entire Baltimore metropolitan area, so that it would be convenient for the people visiting the dealers to get around. Before we went out to see dealers, we were sent to the speech and hearing clinic at Johns Hopkins University, where only the director of the clinic knew about our study.

We were tested by certified clinical audiologists. None of us had what you would call perfect hearing, but despite that fact, aids were recommended by the speech and hearing clinic for only two of us.

Let me give you a few statistical figures. We visited a total of 13 hearing aid offices. Each volunteer visited two or more.

Eleven of the thirteen dealers were visited by more than one volunteer.

Conflicting Recommendations

A total of 21 dealer tests were given. In 11 instances, these tests disagreed with the Hopkins verdict. In nine instances, or 42 percent of the visits, hearings aids were recommended by dealers when the audiologists had recommended none. Two dealers recommended no hearing aid for one volunteer for whom the audiologist found that an aid was needed. In the course of the visits, hearings aids were recommended for four of the six individuals for whom no aids had been recommended by the audiologists.

Of the two who needed aids as recommended by the clinic, one was told "no" that he did not need an aid, and the other one was told "yes," that he did need an aid.

In only two cases did the verdict of the dealers and the verdict of the clinic at Hopkins agree, one was that no aid was needed, and the other was that an aid was needed.

From the consumer point of view, our reports indicate that one of the biggest problems was the difference among dealers.

If we were out to buy a hearing aid, we really would not know what to do, because someone would say the loss is greater in the higher frequencies than the lower frequencies.

There were at least three times when there were different recommendations for which the hearing aid would be advisable, and in each of those instances, Hopkins had not recommended an aid.

There was great confusion on price. The prices ranged from $195 to $420.

There was no way in which you could tell why an aid of $420 was any better than one at $195.

In addition to which there was a difference in senior citizen discount. In one place which two people visited, one was offered a senior citizen discount, but the second volunteer, asking about a senior citizen discount, was told no, we do not give it.

These discounts ranged from 10 percent for one dealer to 30 percent or a flat $100 at another dealer, so there was no way which you could judge comparative value.

Now, as far as these few of our study results—you must realize I am only hitting the very high spots—the volunteers were supposed to call the dealers and ask whether they should see a doctor first before they went in to make an appointment.

Of those of us who followed these instructions, and did ask, all of the dealers said no, come in to see me, you do not need to see a doctor.

In only two cases where an aid was recommended, and the question was repeated, did the dealer say yes, you ought to see a doctor.

In one case, the dealer told the volunteer, "Your hearing is so bad, that instead of getting a hearing aid right away, you ought to have an operation." Thereupon the volunteer told the dealer, "I will go to Johns Hopkins."

"Oh no," said the dealer, "Don't go to Hopkins. You get a lot of interns monkeying around with you, and this is a very serious operation."

"Go to see my friend," and he pulls out of his pocket the card of a doctor who lives in his area.

He said, "You go and see him, he will tell you whether you need a hearing aid or not." By the way, the same dealer told the second

volunteer, whom he refused to test in his office, that she should see this same doctor if she did not want to be tested at home.

Soundproof Room Test

There is technical evidence, which you will find in our report,* that the audiometric tests are based on standards of tests being conducted in a soundproof room.

The dealer's excuse for not testing in a soundproof room was that they did not do this because we do not live in a soundproof world. This sounds very good, but in being tested, you are being rated on a scale that is being based on a soundproof environment.

In one of my personal tests, there were fire engines going by. It was with great difficulty that I persuaded the dealer I did not want to continue the test until the fire engines got by. You are not going to hear the test as well with a lot of noise around you as you are in a soundproof room.

The testing was, generally speaking, not up to the quality of Johns Hopkins. They performed air conduction tests. One dealer, by the way, used a stethoscope-type instrument, and then he told the volunteer he had a 20-percent loss in the left ear and 30-percent loss in the right ear, and he drew up a contract of sale for purchase of an aid.

This gentleman had been told by two other dealers and by Johns Hopkins that he did not need an aid.

Other serious misinformation was given that is very misleading to the consumer.

In the first place, the dealers in three instances said yes, your hearing will be "absolutely normal" after you wear an aid, and in the fourth instance said, your hearing will be "practically normal."

This is not true. Hearing aids are not like eyeglasses. They do not restore your hearing as glasses restore your vision. There are some difficulties with them, and when a person is told that he hears normally, and puts on an aid, and takes it home, and he hears extraneous noises, he becomes so disappointed and disillusioned that he may stop wearing his aid.

Another series of misinformation given was that the auditory nerves need stimulation, and that if they were not stimulated, your hearing would deteriorate.

If you wore a hearing aid, your nerve ends would be stimulated, and your hearing would not get any worse.

The fear motive was used in such statements as: "You know a lot of your friends will not tell you they do not hear."

There is no therapeutic advantage to wearing an aid even though people were told there was.

In 12 instances, these false claims were made to those of us who volunteered.

Now, to sum this up quickly, I would say the results of the Baltimore study are that there are insufficient recommendations for medical examination. The testing is generally unscientific, in a nonsoundproof environment.

*See appendix 1, item 2, p. 84.

False claims are made for normal hearing. There are claims of therapeutic advantages to wearing an aid. The fear of deterioration is false.

Fifty percent of the dealers visited had only one brand to sell.

I would like to say in closing that this is one area that the old saying "caveat emptor" applies; buyer beware is very definitely true.

Senator CHURCH. Thank you very much.

Mr. Dickey, proceed with your statement.

STATEMENT OF FRANK P. DICKEY

Mr. DICKEY. Thank you, Mr. Chairman.

On July 18 and 19, 1968, hearings were held before this committee for substantially the same purposes for which the present hearings have been called. On page 9 of the published hearings, it was said by the Acting Surgeon General:

> The major fault with current State laws is that they do little to protect the consumer. There are no provisions, for example, for recovery of costs of an aid sold improperly, nor any visible restraints against any and all sales practices with the exceptions of false advertising and practices directed primarily at the dealers' competitors. No standards for hearing aid testing and selection are established.

Please note that while the Acting Surgeon General singled out only three examples, his basic statement was that the major fault of current State laws is that they do little to protect the consumer.

That statement was made when only six States had hearing aid dealer licensing laws.

As of today, 38 States have such laws, and the statement made 5 years ago needs very little qualification.

In those 5 years, consumer interests have not been able to find a place in the statutory structure established in early years by legislatures which followed one another, guided by model laws offered by the National Hearing Aid Society, and the Council of State Governments, It was clearly the model law developed by the hearing aid industries that served as a framework on which most State laws have been built.

Now, in barest outline, a hearing aid dealer registration and licensing law sets up an examining board, an advisory committee, or a council with specified duties, prohibits the dealing in hearing aids without a license or registration certificate; requires an examination; sets out certain rules of conduct, and provides penalties; and most important, in my mind, it authorizes the board, whatever it may be called, to issue rules and regulations to implement the act.

That carries us back to the Acting Surgeon General's specific objections of 5 years ago.

First, that there was no provision for cost of an aid sold improperly being recovered.

MANDATORY RESTITUTION

One State recently—Washington—did enact a provision that allows the purchaser to return a hearing aid if he is dissatisfied. If he can show that a physician said he did not need it, it is mandatory that restitution be made.

Senator CHURCH. Is that the only State with such a law?

Mr. DICKEY. That is the only State which has that specific provision.

I have no doubt that an aggrieved hearing aid purchaser could bring a case in court if he could show he was defrauded somehow, but that is not explicit. Second, the Surgeon General objected that there were no standards for hearing aid testing.

Today we call that minimal standards of procedures and equipment, and include periodic inspection of instruments as needed.

Now, bear in mind that the States have the authority to issue rules and regulations.

We have 14 States that have the skeleton provision:

"It is improper to sell a hearing aid to a person not tested with appropriate established procedures and with proper instrumentation in the fitting of hearing aids."

This provision does not tell you very much. Of the 14 States there are only 3 that have issued appropriate and specific regulations telling what the dealer must do.

Senator CHURCH. You are proposing a model statute for States to adopt in this field?

Mr. DICKEY. Yes, sir.

Senator CHURCH. And what would that statute require with respect to——

Mr. DICKEY. That sets out in detail what instruments shall be used, how often they should be calibrated, what the equipment of the dealer must be, and the standards for testing.

Senator CHURCH (continuing). Does that statute require that the person first be examined by a physician or an audiologist?

Mr. DICKEY. Indeed it does. That is set out in the model law.

Senator CHURCH. Would you go into it a little more?

Mr. DICKEY. Yes, sir.

No State requires an examination before going to a hearing aid dealer.

Five States require that if the hearing aid dealer's examination discloses any obvious ear trouble, he must recommend a medical examination, and in those five States, a man cannot be sold a hearing aid until he has had that examination.

In seven States the thing is not quite that easy. If a dealer discovers these obvious defects in the hearing apparatus, he must write a recommendation out to go see an otologist or an audiologist, but the purchaser can disregard that recommendation.

Now, would you like the exact figures?

Senator CHURCH. I am interested in your recommendation that you apparently have made part of this model statute, that would require any person in the market for a hearing aid, or thinks he might need one, first to secure an examination by a specialist.

First of all, let me ask, what degree of specialty is required?

Mr. DICKEY. The proposed law requires an otological examination.

Senator CHURCH. Would such an examination by a medical doctor be sufficient?

Mr. DICKEY. No; it would not, not by a general practitioner.

SPECIALIST—ODDITY IN SMALL TOWNS

Senator CHURCH. Let me just get into that.

I was reared in a town of about 21,000 people when I was growing up, and we did not have any specialists.

An awful lot of people continue to grow up in such towns. The nearest thing we had to a specialist was an eye, ear, nose, and throat specialist, he was an oddity in the city because he was a specialist.

Nobody had ever heard of an audiologist.

Mr. DICKEY. The audiologist is not being discussed at this point.

Senator CHURCH. But do you have any idea of the number of small communities of 3,000 to 5,000 in my own State, that my office actually has to work to try to get a medical doctor into the community, where there is no general practitioner available?

Now, it is really feasible, when you take into consideration the needs of so many people who live in rural communities and small communities, for a State to pass a law requiring such a high degree of specialty before anybody can purchase a hearing aid?

Mr. DICKEY. We took the approach several months ago that the examination could be by either a specialist or a general practitioner, but Elma will now tell you why we changed.

Miss GRIEZEL. What we decided to do, after great disappointment in finding out that general practitioners do not know that much about hearing loss and about hearing aids, was to present the very best model possible we thought the consumer would benefit from.

We realize that in some States this optimum kind of service will not be available, but it is surprising what you can find out in different States about resources.

Michigan is heavily involved in doing research to determine if in their States the requirement that people see either an otolaryngologist or audiologist would be realistic. They have done a county-by-county survey of what exists, and have found, in that particular State, they could meet that requirement.

Minnesota——

Senator CHURCH. Maybe in Michigan and Minnesota that requirement could be met, but I would not need to have research undertaken to state that requirement could be met in my State. Another factor of considerable concern is the cost of the hearing aid.

Have you made any estimate of how much you would add to the present cost by a requirement that physicians examinations be first obtained, how much of an additional factor in cost would this entail for the purchaser of a hearing aid?

Miss GRIESEL. We look at it in a slightly different way.

We realize, and we have been told by many consumers who have written us, that they have bought and purchased hearing aids that they are not wearing, so they have spent $300 to $500, for one hearing aid and much as $1,000 for two hearing aids they are not using.

We thought about that for a long time. It seemed to us that if the consumer spent a little bit extra, say from $35 to $75—whatever that fee might be—by going to a specialist, that if the consumer gets the hearing aid that is best suited for his needs, he will be better off in the long run financially.

SPENDING MONEY USELESSLY ON AIDS

Senator CHURCH. That is an arguable position, and I do know that there are many people who have uselessly spent money on hearing aids, where that might have been avoided had they had the benefit of a physician's advice prior to the purchase, but take your model bill, and

bring it to a State that does not have the luxury of the specialists, and so suppose the legislature simply requires a physician's examination. Does your bill then require the physician to prescribe the type of hearing aid, or the kind of apparatus that this particular person needs?

Mr. DICKEY. It does not specify that.

Senator CHURCH. Is not that analogous to having a law that would prescribe—let's say a person could have a set of dentures, he must first see a dentist, but then the dentist simply sends him down to the dental lab, and let the dental lab fit him out with a pair of dentures, would you think that would be a good law?

Mr. DICKEY. I fail to see your point.

An otolaryngologist can tell whether there are any obstructions of any kind that would interfere with the fitting of a hearing aid.

Senator CHURCH. My point is this, that a dentist can tell a person, if a person needs false teeth or not, but the dentist does not then simply tell the patient to go down to the dental laboratory and have the dental lab technician make you a set of false teeth, does he?

Mr. DICKEY. No.

Senator CHURCH. He does the fitting himself.

Mr. DICKEY. There is nothing in our law that would prohibit the otolaryngologist from specifying a hearing aid.

Senator CHURCH. No, but there is nothing in your law that would require it either.

Miss GRIESEL. In this instance, we have to rely on the professional help that is available in any particular State.

If in one State, all that is available in terms of professional help is a general practitioner, or an audiologist, then we would rely on those people to give the consumer the best possible service.

Like I say, our model bill is based on what we think is an optimum kind of care for a person, and since it is a State model that we are presenting, the argument that you raised is one that would have to be dealt with in the individual States.

If you have specific questions about recommendations from audiologists for hearing aids, we have Dr. Loavenbruck on our staff who can answer questions for you on that.

Senator CHURCH. What I really want to know is: that if a physician's examination is called for, then what is the physician going to say under the provisions of this law?

Apparently a physician will say yes, you ought to have a hearing aid, and that would satisfy the law, and then that person having been told what he already knew, that something is wrong with his hearing, would then go down to the dealer and go through the same procedure that he goes through now.

Miss GRIESEL. Well, there is also the possibility that the doctor would find something medically wrong with the individual.

Senator CHURCH. There is that possibility, and for that reason, I think seeing a physician is a very good thing for a person suffering hearing problems to do.

I am not arguing against that, but I am just wondering what measure of added protection your model bill does in fact confer, other than for those particular cases, or those few cases, I suppose, where some kind of medical treatment is called for.

Relying on Local Physician

Miss Griesel. We feel very strongly that we can rely, or we should be able to rely on the local physician if that should be the case, to give the best referral possible. But our model stresses very strongly the upgrading and improving of the practices of hearing aid dealers that are in existence today.

We realize, of course, that there are hearing aid dealers who are competent, and who are honest and qualified to do their job. We have met some of them and discussed this issue, and most of them have agreed that people should have medical clearance.

For those hearing aid dealers who are in the business who do not meet the specifications that we want them to meet, we have provisions in the model bill which provide the means to upgrade them. There are provisions for educational courses for hearing aid dealers.

Dr. Loavenbruck. Senator, you asked earlier about audiological evaluations, and what they would add to the cost of the hearing aid.

I just like to tell you briefly about my experience with Medicaid in New York State.

In the county where I worked, and this was not true throughout the State, it was required that for a hearing aid to be paid for by Medicaid, the person had to be seen first by a physician, preferably, and, second, it was mandated that the person had to be seen by an audiologist.

The question about adding to the cost of the hearing aid for the State was also asked there.

Since the State was purchasing hearing aids in rather large quantities, they were able to work out with local hearing aid dealers that when a medical referral came from the clinic where I was the audiologist, 20 percent would be deducted from the cost of the hearing aid.

That 20 percent deduction more than paid for the cost of the audiological evaluation, and in addition, the State was insured no person would be given two hearing aids when none was required. So there are ways to handle the additional cost of the audiological evaluation, and when you look at it in terms of the unnecessary hearing aid recommendations made, the cost of audiological evaluation is well worth it.

Senator Church. That experience is very relevant to the question of the possible inclusion of the hearing aids in Medicare, because it does involve a public program, and where you do have a public program of that kind, you may be able to effect savings, because of the volume of purchasers, which is very important as a consideration.

Apart from the model bill proposed for State governments, does the panel have any particular recommendations to make with respect to the possible coverage of hearing aids under the Medicare program?

Mrs. Hamburger. At the present time in 25 States, hearing aids are covered for those over 65.

Senator Church. This has to do with Medicaid?

Mrs. Hamburger. No; many of the regulations in the States have proved to be effective for what should be included in a Medicare program. I also would like to comment that I have reviewed programs in England, Denmark, Sweden, and Australia to give us a basis on which to proceed. In England, for adults, one aid was available through the national health centers.

In Australia, the Government health program provides four body aids, and one behind-the-ear aid.

The Denmark program offers a larger selection.

In the recommendations that we have worked out, I outlined three essential elements that I think have to be met:

(1) A minimum yet sufficient variety of aids at low cost; (2) a distribution system that protects the consumer from abuses and malpractices; and (3) a system that protects the Government against abuses.

National Bureau of Standards Test

Now, as far as purchases are concerned, we recommend that either the VA, which has expertise in this matter, buy the aids and have them tested by the National Bureau of Standards. Or some other Federal agency, with expertise in the area, be the purchaser of all hearing aids. We believe that they should be purchased in bulk.

This would keep the cost of the aids down, and it is the only way we can see that it could be done.

The VA claims $200 per veteran is the cost, and in Denmark, the figure is $200 for an aid which costs $55—the services make up the rest of the costs.

In England it costs less, but they have had the system longer.

We suggest several ways of distribution. We mentioned the possibility of distribution through dealers, but our specific recommendations are as follows:

(1) The purchase of aids in bulk by the Veterans' Administration, or by another experienced Federal agency.

(2) Testing of aids to be continued annually by the National Bureau of Standards to find the best aids and at the cheapest price.

(3) Distribution to be through the VA, nonprofit speech and hearing centers, vocational rehabilitation agencies, with audiological experience, and nonprofit hospitals.

Now, we also point out it may be necessary to face this with a phase-in program over a period of years. In order to get it working properly, we might have to start with a set minimal income level and then proceed to apply it to all people. But this would be the basic idea.

We believe the distributors should provide medical and clinical audiological testing, fitting of aids, an original 3 months supply of batteries, and at least three orientation sessions, these services to be repaid in cost, plus small overhead by the Government, to the nonprofit agencies.

We suggest that future supplies, including batteries and minor repairs, should be the responsibility of the individual clients, except for those who are medically indigent, who are covered by Medicaid.

This would cut down on the cost of the program and would also eliminate some of the complications that would be present in the distribution system.

There should be a provision also for annual visits to clinics by clients to be sure that the hearing aid is being used properly, and that the patient himself is benefitting from a hearing aid. There are some psychological problems involved which can interfere with the adjustment to a hearing aid and this followup visit might help overcome these problems.

Now, you may ask whether this will have a very deleterious effect on dealers.

Senator CHURCH. I was going to ask that.

Mrs. HAMBURGER. In Australia, where I have very specific figures, this is also true in England, but I do not have quite as specific figures, as a result of the publicity that accompanied the free hearing aids, the effect was an increase rather than a decrease in the commercial use of hearing aids.

There has been a snowball effect. At first there was a 2-year drop in private sales, immediately after the free aids were offered.

That was in 1968, but by 1972, there was a 43-percent increase in the number of aids sold as against 1966, which was the base year.

Senator CHURCH. What accounts for that?

If hearing aids are available for nothing under the Government's medical program, why do people purchase them?

Mrs. HAMBURGER. In the first place, more people are aware of hearing aids.

ENGLAND HAS ONE TYPE OF AID

In the second place, and this is particularly true in England, which only offers the one body aid, people may think, well, if I got a behind-the-ear aid, or a better aid from a private dealer, then I would have two aids, and there would always be one available for me to use, and consequently they buy the second aid from the private dealer. This is what has caused the increase.

There has been an overall increase in the use of hearing aids of 117 percent, so that it has worked both ways.

This is what I meant by the snowballing effect.

Senator FONG. A few days ago, I was discussing this matter with an otolaryngologist—ear, nose, and throat specialist.

He was more concerned about the payment by Medicare for the fitting of the hearing aid.

He said that there are many aids, and one aid will not help one man whereas it will help another man, so the fitting was very, very important, and he felt that Medicare should pay for that.

Medicaid now pays for that fitting.

Mrs. HAMBURGER. Yes; doctor's fees would be included in our plan, based on what the State Medicaid programs now do.

There would be a definite service fee paid where the hospital or clinic fitted the aid.

The prescription (recommendations) would be given by the clinic. You would have a prescription like you do for eyeglasses. When you go to get a pair of eyeglasses, the optometrist puts some magical figures on a piece of paper, and you take that to the man who makes the eyeglasses.

Senator FONG. But the aid is already made.

Mrs. HAMBURGER. Yes; and if fitting has to be done extremely carefully——

Senator FONG. Then the person who will be fitted will have a choice of many aids, he will be fitted with aid 1, aid 2, aid 3, and the one best fitted for him then will be bought by him?

Mrs. HAMBURGER. That is the way it will work.

Senator FONG. So, therefore, if you are going to buy these aids in great quantities, you will have to buy different types of aids to be available, so that if this man fits hearing aid 1, he will get that, if he fits hearing aid 3, he will get that, is that the contemplation?

Mrs. HAMBURGER. That is correct. In England they offer only one aid. In Australia they offer five. The VA offers about 20, and with 20 aids, you can really fit practically anybody's needs.

Senator FONG. How many manufacturers of aids are there in the country?

Mrs. HAMBURGER. About 50.

Senator FONG. So, if you have 50, you would cover the whole country?

500 MODELS AVAILABLE

Mrs. HAMBURGER. There are about 500 models now being offered. This is an overproduced industry for the number of people.

This is one of the industry problems—I think Miss Griesel brought out.

Senator FONG. The VA recommendations cover pretty well the number of aids that could be fitted?

Mrs. HAMBURGER. They use approximately 20 aids.

Senator FONG. What is the cost of fitting?

Mrs. HAMBURGER. The cost of a fitting is around $10. The audiologist gets $25. In Kansas, for example, $25 is the audiological examination.

Now, anybody who fits an aid will have to get something to cover his time and energy in the work that he did.

We said in our recommendation that the clinic or hospital, or whatever distribution system should allow for the cost of the mold, a certain amount for the cost of the hearing aid, and further additional sums for the time it takes for hearing aid orientation, because the client has to be helped in how to use an aid—that is part of the fitting.

Senator FONG. Would I be wrong in saying that the cost of fitting comes around $35?

Mrs. HAMBURGER. The whole bit would come around that.

Senator FONG. No, just the fitting.

Mrs. HAMBURGER. Not the orientation, not the ear mold?

Senator FONG. No, just the fitting, to see whether that model fits him or not, would run $35?

This is what I was told.

Dr. LOAVENBRUCK. That is approximately correct.

Senator FONG. What would the orientation cost?

Mrs. HAMBURGER. Well, about $5 a visit.

Senator FONG. Say if I went to the doctor and said I have an impairment of hearing, would I find out the amount of impairment? Then he would send me to whatever agency there is to fit me?

Dr. LOAVENBRUCK. I will give you an example of my work experience with the Medicaid program.

We received referrals for hearing aid evaluation. That hearing aid evaluation was done in at least two sessions, and often many more.

The first part of the evaluation was the hearing evaluation.

That included testing of the person without any hearing aid on to determine what kind of a hearing loss, and in which ear, one or both, that there was need of the amplification. It included extensive counsel-

ing with the individual, about the type of hearing loss he had, what he could expect or not expect from the hearing aid, and so forth.

The cost of that part of the evaluation was $20.

Senator FONG. And that is paid by Medicaid?

Dr. LOAVENBRUCK. That was paid by Medicaid.

Senator FONG. Does Medicaid pay for that now?

Dr. LOAVENBRUCK. Yes, in Rockland County of New York State and some other counties in New York State.

If a hearing aid was determined to be needed, the second part of the evaluation was done in one to 10 sessions, and the cost of that part of the evaluation was another $30, so the whole hearing aid evaluation was $50.

The second part of the evaluation was the actual fitting of the hearing aid. It involved trying on anything from two to five different aids, and testing with each of those aids on the client in order to determine which hearing aid did the most for the person being tested.

Senator FONG. Medicaid paid for that?

Dr. LOAVENBRUCK. Yes.

Senator FONG. Medicare does not?

Dr. LOAVENBRUCK. Not in any State.

MRS. HAMBURGER. The Johns Hopkins hearing evaluation is also $25, and the State of Kansas allows $21 to $25 under its Medicaid program for a hearing evaluation.

Miss GRIESEL. I know we are running over in time.

ALTERNATIVE MODELS AVAILABLE

We do have one thing we are very concerned about. There are alternative models for delivering hearing aids available in the country, and we have taken a look at those particular models.

There are business enterprises which do now sell aids at low cost to the consumer, and they sell a lot of hearing aids. We studied those in depth.

I think these models might come up later in the hearings and depending on what the time factor is, we can submit this information for the written record and go on to other witnesses.

Senator CHURCH. Is there anything further that the panel would like to contribute before we go on?

Mr. DICKEY. I would like to close my testimony. The model bill was prepared after our study of the State laws found them to be inadequate to protect the consumer, just as was indicated in your hearings 5 years ago. The committee will be furnished copies of the model bill.* You will find provisions in our model that we have adopted from other States but there are many provisions other States do not have. First, of course, is the problem of medical clearance.

Second, we believe that consumers should be more heavily represented on State boards, and representation of hearing aid dealers should be reduced.

We have spelled out in the law things which you would expect other States to give you in their regulations, but they simply have not done it. The law is therefore lengthy.

*See appendix 1, item 1, p. 73.

We are indebted to the State laws for what provisions they have supplied us, but we find that the laws do not protect the consumer.

Senator CHURCH. I think I just have one or two general questions for the panel before we go to our next witnesses.

The hearing aid industry says that it must engage in competitive advertising because it sells a product that nobody wants.

In other words, prospective customers are reluctant to admit they have hearing loss, and they must be sold on the idea they can be helped with a hearing aid, and, therefore, this is the reason, the justification for the advertising.

What do you have to say about that?

Mrs. HAMBURGER. I would like to say one thing, if we are to have a successful Medicare program as far as hearing aids are concerned, we also need a public education program along with it. There is more misinformation in this area than any you can imagine. Information is needed to really explain what a hearing aid will do, and what it will not do, what you can expect from using a hearing aid, and what will not happen. In the case of advertising, the dealers are right, it does require a lot of help to get an individual to come in.

For some reason, people are willing to wear eyeglasses, but they are not willing to wear a hearing aid as you and I both know. For some psychological reason, they feel that there is something about wearing a hearing aid that indicates they are old or feeble or crippled in some way.

Miss GRIESEL. We believe very strongly that some of the advertising that now exists tends to perpetuate the negative feeling people have about hearing aids, and the fact that people should hide their hearing aids.

LARGER, BETTER QUALITY AIDS NEEDED

The practice of miniaturizing hearing aids still continues. We have many consumers who have written us, telling us they are now willing to wear, and would love to have, larger hearing aids of better quality.

We think that this should not be the industry's total responsibility to try to sell the public on whether they should wear hearing aids.

The Public Health Service for many years has put out money for all kinds of educational campaigns against health problems such as polio and we feel that Government expenditures should also be made in this direction.

Senator CHURCH. One further question.

The hearing aid industry says 93 percent of persons who use hearing aids are satisfied with their instrument, and they say this is based on public health surveys.

How do you square the findings of your survey with this?

Mrs. HOGAN. Part of the work I did was analyzing the surveys we sent out, and I do not have the exact percentages, but a large percentage of people are satisfied with their aids.

The general feeling our survey gave me is that wearing an aid is better than nothing, and in fact, one of our questions was, what does an aid mean to you? The responses were: it means doing my job, it means being at work. But although they would not be without one, that is not necessarily a sign that everything is perfect.

Miss GRIESEL. Also we have had letters from consumers that they were very pleased with hearing aids, but later, for various reasons, when they would seek medical care, they would be advised that they either did not need a hearing aid because they needed an operation, or that they needed a different kind of hearing aid. They were amazed at the difference when they got a better audiological examination and the appropiate services.

If you do not hear, and you buy a hearing aid, it could be better than your present state, but that does not mean you would not be happier with a better aid or no aid at all.

Ms. WILSON. I would like to address myself to the Market Factors Study which showed that 90 percent of the hearing aid wearers were satisfied.

The way this study was conducted is quite questionable. Dealers submitted the names of their satisfied customers to the professional marketing firm so that discontented customers were purposely excluded from the survey.

Mrs. HOGAN. And the RPAG survey came up with something like 82 percent.

Senator CHURCH. Your own percentage was about 82 percent.

Mrs. HOGAN. Right.

Senator CHURCH. As against the industry's 93 percent.

The journals of the hearing aid industry have asserted that their study, that this study that you have done was based upon a prejudgment by Mr. Nader to the effect the industry is somehow a fraud, and therefore, you have gone on to a conclusion that was anticipated at the time your inquiry was undertaken.

What comment have you to make to that charge?

Miss GRIESEL. When I first came to work with Mr. Nader, we sat down together, and we explored the different areas of concern to older people that he had detected over the years through consumer mail.

One of the things he said was on the top of the list, in terms of the letters he had received, was the fact that hearing aids cost too much, and that people were not receiving adequate services.

We explored that issue together. I had had experience in public health where I knew that a major concern of older people was hearing aids. I think anybody who has been to any conference with older people, whether it relates to health or not, has heard this issue discussed.

CONCERNS OF ELDERLY EXPRESSED

We saw it as a viable consumer issue we should get involved in. We also did a survey of consumer protection agencies around the country, all that we could find. We wrote them and asked about consumer complaints. They indicated to us, even when the complaints were small in number in some areas, that they knew the problem was much more extensive than that, because of concerns of older people expressed at conferences they had attended.

I believe Mr. Nader said in his speech about the industry, that the cost of hearing aids is a fraud.

Most of the letters that come into our organization indicate just that—that people on low, fixed incomes are having to pay $400 to $500 for hearing aids, and they indicate it is a fraud.

Senator FONG. How much would the good hearing aid cost?

Miss GRIESEL. I think Miss Wilson could tell you about a couple of examples of people selling good brands of hearing aids for a cost of $200.

Ms. WILSON. When you talk about the cost of the aid, you are talking about the cost of the instrument. A good instrument would probably cost between $70 and $120 at wholesale.

That is the manufacturer's price to dealers. The second part of the cost of an aid is service, and the extent and type of service needed is varied.

Users who do not need services, should not be compelled to pay the same price as someone getting more service.

Senator FONG. Are you saying that the practice ought to be that the dealer sells the hearing aid at what would be a reasonable markup above his cost, and then he charges for such services as may be necessary on a case-by-case basis?

Ms. WILSON. Yes; we point to this as a type of merchandise pricing system that should be examined.

One dealer in Houston has a system like this, where in addition to the cost of the aid, he may charge $70 for a case history, test, and selection of the aid.

If the customer wants to buy a warranty and loaner during repairs, he would have to pay $20 for that. The customer gets a choice of service, or he could choose to go to the audiologist. It seems to me the dealers are putting monopoly on the cost of the aid and the services. They are not allowing consumers to go elsewhere for them.

Another important alternative that seems to have been very successful, but we are afraid it is in jeopardy, is Master Plan Service Co. in Minneapolis, which has operations in eight cities, including the District of Columbia and Chicago.

It sells quality aids for $99 to $200,

One reason it keeps the price down is because it does little advertising, and no prospective for leads. It does not have to since it takes the clients only on professional and medical referral, including audiologists.

Miss GRIESEL. There are models which do exist, in which you buy hearings aids at a lower cost.

Approximately $200 seems to be a fair price. The dealers who do sell hearing aids at that cost have indicated to us they are selling more hearing aids, and they are making a good livelihood out of that particular kind of business.

Senator CHURCH. Thank you.

Dr. Loavenbruck, proceed with your statement please.

STATEMENT OF ANGELA M. LOAVENBRUCK

Dr. LOAVENBRUCK. Thank you, Senator Church.

The hearing health of many elderly individuals will be immeasurably improved when Medicare begins to provide for the diagnosis and amelioration of hearing impairment through amplification. Hearing health cannot be separated from the overall health of an individual, and it is therefore crucial that Medicare involves itself in the provision of hearing health. The most efficient way to do this, both in terms of financial outlay for the Medicare program and in terms of

providing the consumer with comprehensive services, would be to require that: (1) Both an ENT and an audiological evaluation by a trained master's degreed audiologist be conducted to determine the need for a hearing aid: (2) that testing done for the purpose of diagnosis of hearing loss or fitting of a hearing aid be done only on calibrated equipment under soundproof conditions as specified by the American National Standards Institute; (3) that any amplifying device purchased be as close to advertised specifications as possible; and (4) that adequate followup counseling, as well as any necessary aural rehabilitation, be provided by trained professionals in order to insure successful use of amplification.

How can Medicare administrators be assured that these safeguards are carried out? Since hearing aids are included in the Food and Drug Administration's definition of a "device," FDA has some authority over the hearing aid industry and can address itself to several problems encountered by hearing aid consumers: (1) False and misleading claims made by hearing aid companies for their products; (2) uneven product uniformity; and (3) false claims made by salesmen about when an aid is needed, about aids preventing further hearing loss, or aids restoring normal hearing.

Unfortunately, however, not only is FDA's authority to handle these problems limited, but it has also considered hearing aids a low priority item. The FDA cannot review the safety, reliability, or effectiveness of medical devices prior to marketing. Once the product is marketed, the burden is on the FDA to prove the device is unsafe or unreliable, not on the industry to prove otherwise. FDA needs stronger authority in order to regulate the manufacture and sale of hearing aids. Several bills currently in Congress would give the FDA the additional power it needs.

As far as Medicare is concerned, until the FDA is empowered to take stronger action, many problems in terms of adequate test equipment and environment, incompetent hearing and hearing aid evaluations and adequate counseling and aural rehabilitation therapy can be avoided if evaluation by a physician and a certified masters' degree audiologist are mandated prior to any purchase of a hearing aid.

In terms of hearing aids themselves, however, the FDA should require that industry state uniform performance characteristics for each aid manufactured, that equipment used for measurements meet ANSI specifications, that instructions accompany every aid which state that hearing aids do not prevent further hearing loss and do not restore normal hearing. In addition, the FDA could be instrumental in informing the general public that hearing aids are not like frying pans—to be sold indiscriminately by commercial salesmen—but are medical devices to be purchased only after medical and audiological evaluation.

Senator CHURCH. Thank you, Dr. Loavenbruck.

We will hear now from Wendy Wilson.

STATEMENT OF WENDY L. WILSON

Ms. WILSON. Thank you, Senator Church. Most hearing aids are dispensed by multiline and exclusive dealer establishments at prices ranging from $200 to $450 for one aid. But there are alternative marketing models in certain areas of the country through which hear-

ing impaired people can get amplification at lower cost and still obtain the services they need.

Some of these programs, such as VA and Medicaid, are supported by taxpayers, while others are business establishments well within the free enterprise system which the industry extols. The models I am going to talk about can be developed and expanded in other areas of the country.

Some of the most satisfactory examples are cooperative arrangements between audiologists and dealers regarding the cost of the aid to the consumer. In some communities, audiologists with a large practice have the clout to persuade dealers to lower the price for hearing aids to their clients. And dealers cooperate in sending the client back to the audiologist for a followup check after the dealer has fitted the aid to his client.

An audiologist in Rhode Island, for example, has arranged for his clients to pay only $195 for the aid. Of course, the client must still pay a $30 to $50 fee for an audiological evaluation, but he is still getting a better price and better care than he would by going straight to the dealer.

From dealer's cost to retail price, aids are marked up 200 to 300 percent. According to the industry, one reason for the high markups is the extent of services a dealer must provide. One industry representative said $100 of the cost of the aid covers the cost of dealer services to the customer. But at least one-half of the people who buy aids are previous users who don't need any, or much, service. Why should these people pay the same price as first-time users who do need encouragement and counseling? Further, a person who needs a lot of help adjusting to an aid is better off getting it from auditory training classes or professional counseling. And, in some instances, people never see the dealer after the aid is sold anyway—until the dealer comes around to sell that person a new aid.

Inequities of Pricing System

One answer to this inequity is the fee-for-service marketing system. A few dealers have initiated this pricing system, which itemizes the cost of various services performed by the dealer. Such pricing disclosure allows the consumer to choose the services he believes he needs, above the cost of the aid. For example, at one dealer who uses this system, a consumer can buy (1) a case history, testing and aid selection for $70, and/or (2) an ear examination and an earmold for $20, and/or (3) delivery, fitting and instructions, $30, and/or (4) followup visits and adjustments, $50, and/or (5) warranty service including a loaner during repairs, $20.

A few manufacturers have encouraged their dealers to adopt this pricing system. But the industry has officially opposed it because it believes that such a system would deter the consumer from coming back for counseling. On the contrary, we believe more people would be attracted to lower-priced instruments, and the flexibility to choose services and who is to provide them.

The National Institute for Rehabilitative Engineering is a nonprofit firm in New Jersey which provides foreign aids for around $100

to low-income people, as an adjunct to its regular business of designing and manufacturing electronic equipment for handicapped people.

Master Plan Service Co., a Minneapolis-based operation, is a retailing operation in eight cities, including Chicago and Washington, D.C. It sells aids for $99 to $199. One reason it keeps the price down is because it does little advertising and no prospecting for leads. It doesn't have to since it takes clients only on professional or medical referral. Audiologists are inclined to deal with this firm because it has a reputation for honesty and fairness, as well as giving a price break to clients. Another reason audiologists like Master Plan is because it leaves the testing and followup to the audiologist. MPS does not test clients nor does it own an audiometer. On the other hand, it does own a hearing aid analyzer which allows the company to assure that aids are working properly according to their specifications.

Although in business just over 2 years, Master Plan reports a considerable profit. As might be expected, Master Plan has been vigorously opposed by dealers. Mr. David Nygren, Master Plan's president, has had difficulty in persuading manufacturers to supply their products to him.

Until recently Nygren carried the Oticon product line. In December 1972, after it had become known that Master Plan was not being guided by manufacturers' suggested retail prices but was supplying aids at low cost. Oticon decided to withdraw its line from Master Plan's Chicago office. the company wrote:

> We feel that your program for distribution of our hearing aids could very well disrupt our distribution setup, and for this reason and other reasons, we must advise you we are not at this time in a position to supply to your company hearing aids for distribution in the Chicago area.

About 4 months later, Oticon withdrew its line from all Master Plan offices, writing:

> We regret this letter has to be written, but as supplier of "hardware" we have no choice but to protect and create reasonable growth in our business, and for reasons described in our previous letter, this is becoming increasingly difficult.

After Oticon dropped Master Plan, the company received a letter from Norelco agreeing to supply it. Norelco granted Master Plan $10,000 in credit. But when Norelco dealers in New Jersey and New York threatened to call an unofficial boycott if Norelco supplied Master Plan, Norelco reneged on its offer.

Bond of Protection for Dealers

One would think manufacturers' major interest is high volume sales. Norelco, which does not have a very high volume business relative to other hearing aid manufacturers, would normally relish the opportunity to have Master Plan, a high volume retailer, handle its products.

But instead, Norelco chose to follow the traditional industry marketing pattern of providing a tight bond of protection for its dealers. This is accomplished through the practices of exclusive dealing and territorial restrictions. Dealers who subscribe to this marketing method agree to carry only one brand and sell it in only one specific territory. Manufacturers guarantee the dealer that no other dealer will be selling that brand in his area. The result is no intrabrand competi-

tion. Thus, in selling its products to Master Plan, Norelco would not be protecting its dealers from competition in Master Plan's areas of operation.

In order to attract dealers, manufacturers promise them generous profit margins. In fact, two industry representatives told us the manufacturers suggest retail prices at a level which guarantees the most inefficient dealer a comfortable living. This weds dealers to manufacturers and makes them responsive to manufacturers' marketing demands At the same time, it discounts the possibility that manufacturers can support lower retail prices.

The FTC maintains that five of the eight largest manufacturers in the industry "fix, establish, control, and maintain" retail prices at which dealers sell their hearing aids. In complaints issued in October 1972, the FTC said that manufacturers' activities such as exclusive dealing and territorial restrictions tend to be "oppressive, coercive, unfair, and anticompetitive."

The five companies—Beltone, Dahlberg, Maico, Radioear, and Sonotone—were cited for engaging in anticompetitive activities which violate section 5 of the Federal Trade Commission Act. As of this date, only two companies—Radioear and Sonotone—have signed consent orders; the remaining three are contesting the charges in court.

The traditional manufacturer-dealer links appear to be a barrier to any entrepreneur who wants to provide cheaper and better marketing alternatives. The FTC should take vigorous action to break them up and monitor the activities of manufacturers and dealers.

Meanwhile, Master Plan is the catalyst which restored competition to the hearing aid business in Minneapolis. Five other brand name dealers in the city have recently lowered their prices to those of Master Plan, and a number of dealers have gone out of business. This is the real free enterprise system at work.

Finally, while the VA is not a private business operation available to all members of any community, it is a model that demonstrates how low the cost can go and how efficient a program can be.

This system is universally attacked by dealers and manufacturers because VA buys directly from manufacturers, eliminating all but a few dealers from selling to veterans. The possibility that VA's example might be used by legislators to set up future Government programs stimulates vehement dealer attacks to undermine the validity of the VA program.

The per-person cost to the Government of the VA program is $208.84 (fiscal 1972), according to Dr. G. Donald Causey, the chief of the program. This figure includes average price of the aid, medical services, NBS testing program, audiological evaluation and earmold, aural rehabilitation, and the veteran's travel. This cost has not been duplicated anywhere in the private enterprise system.

Industry Attacks VA Program

The industry claims the average VA expenditure per veteran exceeds $800 but it fails to substantiate such allegations. Industry attacks the VA program by proposing that VA, in the accounting, fails to include items such as depreciation on equipment. In response to this charge, VA officials told RPAG that all costs had been included in the

report. One major reason that the cost is so low is that only 20 percent of the VA's time and resources is spent on the hearing aid program.

And the veterans gets a very comprehensive counseling service and followup instructions: 2 days or more, according to VA officials. When a veterans leaves the center, he is reasonably well adjusted to his aid. Undoubtedly this is more attention than many individuals receive from dealers.

Senator CHURCH. I just want to make one final comment.

I noticed among the panel there are a number of retired professionals, and I just simply want to commend you for staying active and contributing to this effort that the panel made that demonstrates that retirement by no means connotes idleness and everybody has profited from your inquiry and from your recommendations.

Certainly the committee will give your recommendations serious attention as it grapples with this old problem.

I want to thank you very much for your testimony this afternoon.

Miss GRIESEL. Thank you, Mr. Chairman.

Senator CHURCH. Our next witness, Dr. Johnson.

The hearing aid industry is listed on our agenda as last this afternoon. I am told by Mr. Oriol that they had been offered this slot coming right after the Nader panel and preferred to wait until the end of the testimony today before making their presentation. I am hopeful that we do not run out of time because of votes on the Senate floor. Some votes are anticipated but I simply want it understood that we are putting the industry over until later this afternoon for purposes of delaying their testimony but this was done in accordance with their own request. Very well. Dr. Johnson, Dr. McLaughlin. We welcome you to the committee and please proceed.

STATEMENT OF KENNETH O. JOHNSON, PH. D., EXECUTIVE SECRETARY, AMERICAN SPEECH AND HEARING ASSOCIATION; ACCOMPANIED BY RICHARD DOWLING, DIRECTOR OF GOVERNMENTAL AFFAIRS; AND ROBERT McLAUCHLIN, ASSOCIATE SECRETARY FOR AUDIOLOGY AFFAIRS

Dr. JOHNSON. I have asked Mr. Richard Dowling, director of governmental affairs, and Dr. Robert McLauchlin, associate secretary for audiology affairs, American Speech and Hearing Association, to join us here. I am Kenneth Johnson, executive secretary, American Speech and Hearing Association. I earned my Ph. D. in audiology from Stanford University and I am very pleased to say that under my responsibility and during my tenure as Chief of the Veterans' Administration audiology program from 1954 through 1956, the current Veterans' Administration hearing aid purchasing and distribution program was developed. I think that program is one of the most important and successful adventures in the health field, particularly for the hearing handicapped. We have submitted a written statement for inclusion in the record today.* I merely wish to make some supplemental remarks to underscore two of the particularly strong feelings we have in this matter. Our first recommendation is that the Senate Finance

*See appendix 2, item 1, p. 105.

Committee and the House Ways and Means Committee begin to grapple with legislation to provide, under the Medicare law, reimbursement for hearing aids and related professional services on the written order or prescription of audiologist's or physicians specializing in diseases of the ear. The rationale for our recommendation is, first of all, that the present system is defective and will not change voluntarily. Second, the cost of hearing aids under the present system represents an impossible burden for both the elderly and the poor in this country. Let us look at why hearing aids are so expensive and why the system is probably not going to change voluntarily. The industry made a basic decision a good many years ago—after some experimentation on the part of some manufacturers with different distribution systems—that their hearing aid offices would be characterized by personalized services.

Average Dealer Sells Eight Aids Monthly

In addition, they concluded that they must make a strenuous effort to create a professional atmosphere in these sales offices. The industry undoubtedly discovered it could sell more hearing aids in a personalized, pseudo-professional environment than it could in the over-the-counter drugstore type of operation. Senator Church, as you stated earlier, the industry concluded that hearing aids must be sold, that they will not sell themselves. Now add to their decision concerning the nature of the environment in which aids were to be sold the facts that: (1) There are some 35 or more assemblers—that is what they are mostly—or manufacturers of hearing aids; (2) there are only 600,000 hearing aids purchased yearly; and (3) there are some 6,000 dealers offices where hearing aids are sold. It is obvious that if a dealer sells eight hearing aids a month, that is probably a pretty good average. Now, in order to pay your rent and in order to eat, the dealer must sell those eight aids at a very substantial markup. Obviously, it is difficult to change the structure of the markup in such a distribution system. Next, let us consider the fundamental defect in the system. The system of distributing hearing aids in this country is based on a fundamental conflict of interest. It pits the financial interests of the seller against the economic and health interests of the buyer and permits the seller, in most instances, to choose among the alternatives. Now, whenever a hearing aid is sold, two important choices or alternatives have been made. The first choice is: "Should a hearing aid be worn or should it not be worn?" In other words, is the hearing aid needed or is it not needed? If the answer to that question is "yes," then there is another decision: "Which hearing aid should be worn, hearing aid 'A' or hearing aid 'B'?" From the previous testimony presented by Mr. Nader's Retired Professional Action Group we have heard evidence of the great conflict of interests inherent in this system. It is essential for individuals to make a living and, in order to make a living selling hearing aids, it is necessary to sell aids in many, many instances where they are either unnecessary, undesirable, or of potential harm to the user. This committee is well aware of the many examples which could be presented here as evidence of the impact of this conflict of interest in the hearing aid distribution system. The records for the 1962 Kefauver hearings and for your 1968 hearings

provide many examples of the problems which result from the sale of hearing aids to individuals who should not have been sold them.

Now, because of the nature of the distribution system, because of the supply and demand facts we have indicated, and because of the conflict of interests which is inherent in the system as it currently exists, we make our recommendations concerning modifications of the Medicare law. The modification suggested would eliminate the conflict of interest situation. Under our recommendation, the professional services would be provided on a fee-for-service basis. Essentially, after initial or preliminary audiological examination and a determination that a hearing aid would be a usable device for a given individual, the fee to be charged for the services rendered would be essentially the same, whether or not a hearing aid was recommended or prescribed. The fundamental conflict inherent in the present system would be avoided. Most assuredly, there would be no difference in the fees charged for the professional services rendered if aid "A" was prescribed or if aid "B" was prescribed.

Second, of course, we make our recommendations for modifications in the Medicaid law because they would make it possible for hearing aids to be obtained by the elderly, large numbers of whom at the present time are completely unable to afford them.

Adequate Supply of Professional Services

From some quarters, particularly the hearing aid industry itself, statements are made which suggest that the numbers of audiologists and physicians are not sufficient to meet the needs. Perhaps we can lay that false charge to rest for all time. The data available indicate there are about 20.8 million Americans 65 years of age and older, and of those, about 6 million at most have sufficient bilateral hearing loss to warrant consideration of the use of a hearing aid. If we assume that a reasonable average life of the hearing aid is 5 years and that each person will require an average of perhaps 3.5 hours of professional services during this period, that there are nearly 3,000 audiologists currently recognized by the Social Security Administration, and about 6,000 physicians specializing in diseases of the ear, there can be no question that the elderly population would have more than an adequate supply of appropriate professional services available should the Medicare law be changed as we have recommended.

Senator Church. Have you looked at the distribution of these professional hearing specialists? Are you certain that they are within feasible reach of most people?

Dr. Johnson. We recognize that the distribution of services in the health field is a critical matter in all areas, not just in the area of hearing. Last week, in New Orleans, I had an opportunity to talk with Dr. William Stewart, the former Surgeon General. He commended the field of audiology for its efforts to improve services to the hearing handicapped. Dr. Stewart spoke also of the general problem of providing services in remote and less populated areas and stated that this was the No. 1 health services problem. The problem is with us today in delivering hearing aids through a commercial system and it would be with us tomorrow should hearing aids be distributed through professional channels as we recommend.

Senator CHURCH. But you are proposing substitution of one system for another?

Dr. JOHNSON. Correct.

Senator CHURCH. And much of what you say seems to have great merit. The only problem is, do we really have a new system to substitute that will, in fact, reach the people in need, because as you know, there has been a great tendency for specialists to congregate in the larger metropolitan areas and so, I just wonder whether you are in a position to substitute for the present system of a better system that will really do the job?

Dr. JOHNSON. There are 1,100 to 1,200 speech and hearing facilities in the country, not counting private practitioners and facilities available in the public schools. As I indicated, there are roughly 3,000 audiologists currently recognized by the Social Security Administration and we anticipate the number to double within the next 5 years.* But we know how health services are delivered in this country and so if you double, triple, or even quadruple the number of health personnel, they will probably never reach some smaller communities; transportation problems are certain to exist. The VA solved the problem in its own way, but it is a difficult problem.

PURCHASE AND DISTRIBUTION PROGRAM

Our second recommendation is in part related to a recommendation which you heard from the Retired Professional Action Group. We urge, as we did in 1968, that the control of costs of hearing aids be effected through the establishment of a national hearing aid purchasing and distribution program. The VA model does provide us with an excellent and successful example. It has withstood the challenges of the hearing aid industry and continues to be looked upon as an effective system. Hearing aids purchased through a national center could be distributed to all Federal and Federal-State beneficiaries. One example, of course, would be the Medicare beneficiary, should the law be changed, but there are others: Maternal and child health beneficiaries, vocational rehabilitation beneficiaries, and so on.

The total cost of the hearing aid, in my judgment, including the cost of professional services, should be under $200. If we say that the cost of the hearing aid itself can be obtained wholesale for $100—and that seems to be a generally accepted figure—the total cost of the professional services involved, including otological and audiological services, would not exceed $100. There need be no markup of the cost of the hearing aid. Aids could be distributed at a cost approximating that of the cost of the aid to the national center plus the professional services fee. As I said, the total cost would be less than $200.

Senator CHURCH. Under your recommendation, insofar as the fitting and furnishing of hearing aids to Medicare beneficiaries or other beneficiaries of Federal programs is concerned, the dealer would be eliminated?

Dr. JOHNSON. Yes; I see no reason for the dealer to be involved. Of course, there are many possible variations on this theme.

Under one possible variation, hearing aids could actually be distributed by the dealer, but as soon as that is done, you increase the total costs.

*See appendix 2, item 3, p. 109.

Senator CHURCH. Your recommendation within the framework of the Federal program for beneficiaries would eliminate the dealer?

Dr. JOHNSON. Yes.

Senator CHURCH. Now, you think that would reduce the cost to about $200 or to something under $200?

Dr. JOHNSON. Correct.

Senator FONG. Of the number of aids that are now sold, how many have been sold to persons 65 and over; and how many have been sold to persons under that age?

Dr. JOHNSON. It is my understanding about 45 or 50 percent of the hearing aids sold today, 600,000 or so, are sold to the people 65 years and over. The industry witnesses will, of course, be able to give you more accurate figures.

Senator CHURCH. There is presently a vote in the Senate. We still have a long way to go this afternoon, so I am going to ask you to continue with your testimony. I will be back as soon as I can, and I am sure Senator Fong will try to get back, but meanwhile let's continue with the record and the staff may have questions in our absence.

Dr. JOHNSON. Further cost control is possible. If the $200 figure per aid is more than the Government could afford, the total cost of the proposed hearing aid distribution program could be reduced by reducing the size of the population eligible for aids under Medicare. The population eligible for aids could easily be limited to persons with moderate to severe hearing losses. Costs could be predicted and carefully controlled by this method.

In conclusion, then, as a minimum, the elderly and the poor in need of hearing aids should be able to obtain them at a reasonable cost, in conjunction with objective, professional services, free of the conflict of interests inherent in the present delivery system. The cost of these aids and related professional services, we believe, should be reimbursable under Medicare. Our written testimony* presents additional recommendations which we hope will be of interest to the committee. Thank you very much.

MASS PURCHASING BY GOVERNMENT

Mr. ORIOL. Thank you. My name is Bill Oriol. I am the staff director for the committee. In a moment, I suspect the minority staff director, Mr. John Guy Miller will return and we will attempt to keep the hearing going while Senator Church is out. Dr. Johnson, we are very fortunate to have someone who is so closely identified with the VA program, especially since you have recommended, in effect, mass purchasing, not just in effect, you have recommended mass purchasing by the Federal Government to supply those hearing aids that would be dispensed under Medicare, should Medicare coverage be extended. Now, to most laymen, that suggests some sort of monumental depot, where hearing aids are stored, and the question is, how do you get the right hearing aid to the person who needs it and what sort of purchasing do you have to engage in to make certain that the proper hearing aid reaches the person who needs it?

Dr. JOHNSON. The hearing aid stock in the VA is determined on the basis of bids submitted by the manufacturers—which has an obvi-

*See appendix 2, item 1, p. 105.

ous effect on the price—and a series of elaborate tests conducted by the National Bureau of Standards on an annual basis. Once the determination has been made which of the hearing aids will be stocked in clinics, the problem of getting them to the clinics is relatively minor. Manufacturers could be directed to distribute to qualified individuals or registered clinics a specific number of aids.

Mr. ORIOL. How many models does the VA program now stock?

Dr. JOHNSON. The previous witness, I believe, said 20. It is my understanding that the number is about 30. But I do not know for certain exactly how many they stock.

Mr. ORIOL. Can you give us an estimate of how many models are on the market?

Dr. JOHNSON. We cannot.

Mr. ORIOL. Is it conservative to say dozens?

Dr. JOHNSON. Yes, many dozens. There are 35 or more assemblers or manufacturers. So there are probably 300 or more different models on the market.

Mr. ORIOL. From all of that number, the VA has whittled it down to 20?

Dr. JOHNSON. Yes; or 30.

Mr. ORIOL. And that meets the needs of the veterans served by the programs?

Dr. JOHNSON. Yes. For all practical purposes, the VA stock will meet the needs of all the people in the United States who need aids.

Mr. ORIOL. If Medicare—I misunderstood that. The VA program, of course, serves only veterans?

Dr. JOHNSON. Yes. There are various hearing needs of people, not all people can utilize the same hearing aid. The VA, in selecting 20 to 30 hearing aids, wanted to make certain they had available to them under contract enough hearing aids to serve all the auditory problems veterans have, and I am saying to you that those problems are the same in the general population. However, the stock of aids could be modified and expanded if the needs of the hearing impaired elderly population were found to be different from those of the VA population.

Mr. ORIOL. I just would like you to know that Mr. Miller is here. John, I have already introduced you. The general conclusion is, Dr. Johnson, that with your experience with the VA programs, you are convinced the VA experience indicated it would work, primarily, for the older people?

Dr. JOHNSON. Yes, without question.

Mr. ORIOL. You have asked for Federal training programs to increase the number of practitioners capable of providing help for the hearing handicapped. Would you describe the extent of current efforts and tell us why you believe the number of ASHA certified audiologists is expected to more than double within 5 years?

DOUBLING OF AUDIOLOGISTS IN 5 YEARS

Dr. JOHNSON. On the latter point, we have been doing a manpower study of our field. We know there are 32,000 people in undergraduate speech pathology and audiology training programs in our universities; close to 8,000 are seeking masters degrees and between 1,100 and 1,200 are seeking doctorates. The estimate of a doubling of the population of

certified audiologists within the next 5 years involves these figures, the conservative assumption that a little more than half our undergraduates go on to achieve graduate degrees, and the fact that about 18 percent of our new members are audiologists.

Mr. ORIOL. For our hearing record, may we have a description of the training programs and your projections. I think that will be a very useful item in the record.

Mr. MILLER. Bill, may I interject a question? According to the hearing aid industry, every study indicates that it costs more for a Government agency than a private agency to provide hearing aids for the hard of hearing, including the hearing aid itself, salaries, overhead, maintenance of the aid, and services to the owner. Reference has been made to the VA. Do you have information of what the total cost of provision of hearing aids to the VA runs per aid?

Dr. JOHNSON. It is my indication the VA reports $150 as their cost. I believe the previous witness indicated $200.

Mr. ORIOL. We have a report here indicating the estimate of total cost of furnishing hearing aid to a veteran at $209.

Mr. MILLER. Does that cost include everything, the maintenance and what you might call the VA's overhead or is that just direct cost?

Mr. ORIOL. This figure includes costs associated with the National Bureau of Standards, measurement, storage and supply depot, professional and clerical salaries, veterans' travel, and cost of purchase from the manufacturer but it does not specify measurement services but it may include that. According to a Hearing Aid Industry Conference paper, many clinics, and that is those serving the handicapped, are crowded, overburdened, requiring weeks or months waiting. Do you regard that as an accurate description?

Dr. JOHNSON. Not at all. Audiology programs are increasingly utilized and are under pressure to expand their services. Unfortunately for the public, almost all of the audiology services are provided under a nonprofit structure. There are only a few audiologists in the United States who provide services on an independent basis. The mass of audiological services are provided in small community supported centers; but the pressure for such services is considerable.

Mr. ORIOL. You are right, but there, too, the attractiveness of the services is one of the factors that attract people.

Dr. JOHNSON. I think that the pressure for audiological services is testimony to the value of the service as seen by medical specialists and others, including the general public. There is no question about the fact that our training programs have need to expand and they have been expanding. I have indicated to you we have now about 32,000 young people in our undergraduate college university programs. There is need for further expansion.

ASSOCIATION'S RESOLUTION 13

Mr. ORIOL. We are informed by the hearing aid industry that you are the coordinator of the American Speech and Hearing Association's committee which developed what was known as resolution 13.* According to the industry, this resolution would place audiologists in direct commercial competition with the Nation's hearing aid dealers

*See appendix 2, item 17, p. 165.

in the sale of hearing aids. What circumstances promoted this proposed resolution and do you feel that audiologists are indeed interested in competing with hearing aid dealers in the fitting of hearing aids?

Dr. JOHNSON. The resolution referred to was adopted by the legislative council of the American Speech and Hearing Association, and expressed general support for the idea that audiologists should become involved in the dispensing of hearing aids. It left to the executive board of the association the task of approving a plan which, after 2 years of effort, we have still not been able to develop. We have not been able to develop a plan which is generally acceptable to the audiological membership of the association because of the insistence that any such system operate objectively and clearly without a conflict of interest. We have insisted since the inception of this profession, that our people not be involved in commercial activities. That is part of our code of ethics. They must not allow their own financial interests to interfere with their objective services to the public. What will happen in this matter is, I think, still subject to question. We have raised certain questions about the involvement of our people in dispensing hearing aids with the Justice Department and certain questions are being considered at the present time.

Mr. ORIOL. Doctor, I would like to note for the record that Mr. Dowling, before this hearing, submitted a letter to this committee* discussing the matter of the Patent Office's trademark division designation of audiologists, and we will include that, without objection, in the hearing record and submit it to the industry for their comment.

Mr. DOWLING. Thank you.

Mr. ORIOL. Of course, your prepared statement will be in the appendix of the hearing record** and if any additional matters arise in the course of this hearing that you feel you would like to comment on, you are certainly welcome.

Dr. JOHNSON. Thank you very much.

Mr. ORIOL. Our next witness panel, Dr. Roy Sullivan, associate professor of audiology, Adelphi University, accompanied by Dr. David Resnick, director, hearing and speech center, Washington Hospital Center. Both witnesses have heard the testimony today and if you feel you would like to summarize your testimony to omit discussion of material covered, feel free to do so.

STATEMENT OF DAVID RESNICK, PH. D., DIRECTOR, HEARING AND SPEECH CENTER, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C.

Dr. RESNICK. Mr. Chairman, members of the subcommittee, I have already submitted testimony which I would like included in the record.***

I am appreciative of the opportunity to appear before you to answer questions concerning the delivery of hearing services to the elderly.

For as many years as I have been providing professional services to the hearing impaired I have been aware of dissatisfactions, both on

*See appendix 2, item 2, p. 108.
**See appendix 2, item 1, p. 105.
***See appendix 2, item 6, p. 122.

the part of the profession and the industry, with the methods of delivering hearing services and hearing aids to those seeking help for auditory limitations. Similarly I am cognizant that the average individual with a hearing loss knows not how to select the best route to improve hearing, is dazzled by misleading hearing aid advertising, and is stunned by the cost of the hearing prosthesis that purportedly "returns hearing to normal."

Most people who suspect a hearing loss visit the nearest hearing aid salesroom where they place the management of the Nation's number one physical disability squarely in the hands of a product oriented, profit-motivated salesperson. A salesperson, who compared to an audiologist, is sorely lacking in the training and equipment necessary to to define the auditory deficit, and abysmally deficient in the training and skills of rehabilitative service so vital to effective hearing aid use. Professional literature, consumer reports, slick magazines, Government and health agency publications, and newspaper articles have all, over the years, pointed out the recommended steps to hearing health. Each of these sources places the hearing aid sales office as the last, not the first, step in the procedure. And yet we continue to remain in quandry, spinning with the shameful inadequacies in the delivery of hearing services that have been apparent for more than two decades.

Objective Service at Less Cost

The time is ripe for change—not for the sake of change, but for the sake of improving a system for the welfare of the hearing handicapped older American. It is with considerable gratification that I view the efforts of my own organization, the American Speech and Hearing Association, in evaluating the possibility of audiologists becoming directly involved in the dispensing of hearing aids as a means of providing objective service at less cost. The issues involved therein are indeed weighty, and perhaps unsolvable. Nonetheless, the scholarly deliberations of the association in this matter are at least an expression of a desire for improvement in the management of hearing loss.

Likewise I am gratified to witness innovations in the delivery of hearing aids as introduced recently by Behavioral Prosthetics, and Master Plan Service. The introduction of these innovations, and there are at least two, suggest that some commercial factions are marching to a different drummer, a drummer who is playing a rock tempo, solid, definite, and "in" with the times.

If we are truly set about the business of improving hearing services, of minimizing the cost, of insuring objectivity, of protecting the consumer, then we must be able to admit current shortcomings, recognize and support positive strides, and press to achieve that which appears better. Thank you.

Mr. Oriol. Thank you very much for abbreviating your testimony. Fortunately, we had it in advance so we are able to ask questions based on your total presentation. What is the basis for your statement that 75 percent of the 500,000 hearing aids distributed this year are placed in the ears of the consumer by dealers without referral of a physician or audiologist?

Dr. Resnick. I believe that is a statistic that comes from the hearing aid industry that has appeared in the National Hearing Aid Journal.

Previously, I believe the statistic quoted was that 10 to 12 percent of the total came from professional sources. Currently, it is around 25 percent; 75 percent, therefore, remains for the dealers to recommend on their own.

Mr. ORIOL. So you base that solely on industry figures?

Dr. RESNICK. Yes.

Mr. ORIOL. Your statement, "The hearing aid dealer's place is becoming clouded with the issues of realism." Is it your view that the dealer should be completely eliminated from the delivery system, and if so, do you envision the audiologist as a fitter of hearing aids as well as a prescriber?

Dr. RESNICK. Let me start with the last part of the question first. I certainly see the audiologists as the prescriber of instruments. I see no place for any management of hearing loss program which does not include professional examination and a professional prescription, a professional recommendation for a specific fitting. I think the situation as it presently exists, where anyone at any time can walk into a hearing aid sales office and obtain a hearing aid from someone who has a conflict of interest; that is, where the decision as to whether that hearing aid is needed or not needed is left to the person who stands to gain financially from that decision, is totally wrong.

STATE LICENSING LAWS

Mr. ORIOL. You say conflict of interest. The industry says they have a code of ethics. You do not believe that the code of ethics is strong enough to do that? Are there no State licensing laws?

Dr. RESNICK. I have no evidence that there has been a substantial number of dealers called on the carpet for violations of that code of ethics or licensing laws. My statement refers specifically to conflicts arising because there is profit involved in the sale of the prosthesis and the decision as to whether that prosthesis should or should not be sold is left to the man selling it. Neither the code of ethics nor State licensing alters this situation.

Mr. MILLER. Would you say there is a similar conflict of interest in the practice of optometry?

Dr. RESNICK. I do not know that I am able to answer that. When you say optometry——

Mr. MILLER. Optometrists, I believe, do prescribe and sell eyeglasses.

Dr. RESNICK. As opposed to the optician?

Mr. MILLER. Yes.

Dr. RESNICK. No, I think there is a different degree of professional training with the optometrist which does not parallel the training in the hearing aid business.

Mr. MILLER. You referred to the difference in training. My question related to your claim of a conflict of interest, the fitting factor.

Dr. RESNICK. Yes, I think I still have to answer the same way. I think the training in optometry is professional rather than sales oriented. That is not the case when you are talking about hearing aid salespeople.

Nonetheless, one cannot deny the potential conflict of interest arising when a profit is involved in the sale of merchandise. It is this very consideration that has plagued those of us in the ASHA concerned with

the possibility of audiologists dispensing hearing aids. How do we keep that profit conflict in perspective? There is little doubt in my mind that optometry is able to do it because part of their income is derived from fees for professional service. They are not solely reliant on the sale of the eyeglasses. Also, their training is professionally based; they are not trained as salespeople with annual quotas and draws against commission. Little if any dealer income is derived from service fees. It is predominantly from the sale of a product, the hearing aid. They are trained in the rudiments of fitting in order to sell a product.

Mr. MILLER. Then, with adequate professional training of the hearing aid dealer, you would be equally satisfied?

Dr. RESNICK. No, I would not be equally satisfied.

Mr. MILLER. I have no further questions on that one.

Dr. RESNICK. I can answer that question a little further, if I may.

Mr. ORIOL. Please do.

Dr. RESNICK. I would be somewhat more satisfied if the dealers would charge for services and the instruments separately. In other words, everyone pays one charge, which incorporates all of the things that they say they deliver, in terms of testing, in terms of fitting, in terms of handholding, afterfitting care, et cetera. This is presently included in the charge for the instrument. The question that you have to ask here relates to how many customers actually get all of that afterfitting care, all of the handholding, all of the counseling that is needed. If only 5 out of 10 come back for that afterfitting care, then of those 5, how many are coming back simply because they are dissatisfied with the price or what they expected the hearing aid to do, and for those that are dissatisfied for that reason, that requires really a sales oriented talk session. Maybe, then, we are left with two or three people who are really to be counseled relative to their hearing problem. But they all pay equally. I have two other questions. One would have to be whether the dealers are truly qualified to manage all kinds of afterfitting problems, those that relate to the adjustment to the hearing aid, the psychology of the hearing impaired. The other question refers to what kind of a system where people are paying for something they do not get; all are paying for services that only a few people really obtain.

MASTER PLAN SYSTEM

Mr. ORIOL. Dr. Resnick, you said just now, new methods in providing the hearing aids are developing by people perhaps marching to a rock tempo. You mentioned a Master Plan; and I believe you are presently operating with this Master Plan system. Would you tell us a little bit more about your experiences, about how you work with Master Plan?

Dr. RESNICK. I think first I should preface this by saying I have no obligation to Master Plan, no allegiance to them in any way. They simply represent at the moment a means of providing a service to the hearing impaired population, that is far better than anything else presently available to me. I think the Master Plan system and the concept that is described by Behaviorial Prosthetics, as another example, represents the concerns of this committee. First, they are providing an instrument——

Mr. ORIOL. How many models does Master Plan represent?

Dr. RESNICK. Master Plan originally started with three brands. They are now down to one, which does not make me happy at all. It represents——

Mr. ORIOL. Why are they down to one?

Dr. RESNICK. They are down to one because the industry will not supply them with others. Most manufacturers will not sell to them.

Mr. ORIOL. How can you verify that?

Dr. RESNICK. I have submitted, as part of my testimony,* letters from one manufacturer that supports that answer; they would not continue to supply Master Plan with additional instruments.

Mr. ORIOL. We will submit that here to the manufacturers who apparently produced it and ask him to comment.

Dr. RESNICK. Do you have copies of that?

Mr. ORIOL. Yes, we do. You have indicated you were satisfied with the Master Plan but you have some reservations?

Dr. RESNICK. My reservation at the moment is that they are down to a single brand of hearing aid, which means if I am not able to satisfy the hearing problem with that one brand of instrument, then I must refer a patient to the customary hearing aid dealer and that, unfortunately, is costing the patient more dollars than it would if I could refer to Master Plan.

Mr. ORIOL. Why is that?

Dr. RESNICK. The local dealers, in general, are not willing to sell for a price competitive to Master Plan?

Mr. ORIOL. What is the difference?

Dr. RESNICK. Master Plan dispenses aids in a range from $99 to $199. The average cost of a hearing aid from other local dealers, aids that we recommend and prescribe, is from $300 to $350.

Mr. ORIOL. You have provided the committee with what is identified as a confidential memorandum of August 27, 1973, entitled, "Hearing Aid Specialists Have No Unique Capacity for Unethical Practices or Incompetency."* How did you obtain this memorandum and what conclusions do you draw from it and what is the source?

MISHANDLING OF PATIENTS

Dr. RESNICK. The memorandum to which you refer is one put out by the National Hearing Aid Society. It is, as you say, marked confidential. It is dated August 27, 1973, and it is entitled, "Hearing Specialists Have No Unique Capacity for Unethical Practices or Incompetency," and signed by the executive secretary of the National Hearing Aid Society. I obtained it through a hearing aid dispenser who gave it to me and simply said, "Are you aware of what the dealers organization is attempting to do to the profession?" My reaction to the memo is not good. It asks for dealers to search their files and submit to the National Hearing Aid Society records that will indicate any or all of five different inadequacies on the part of audiologists, such as: A hearing aid recommendation which was made by a clinical audiologist to provide a hearing aid for a person who was later found to be a malingerer; the clinical audiologist said a hearing aid would not im-

*Retained in committee files.

prove hearing ability when in fact one did, and so on. How do I view the memo? I view it as an attempt on the part of the National Hearing Aid Society to gather a good deal of information that hearing aid dealers are perhaps doing nothing any differently than audiologists are, that audiologists may make mistakes, to which I would readily admit.

I am sure if I were to search my own files, I would find not only cases where patients have been mishandled by a dealer, but also cases where perhaps audiologists would do things a litttle differently, not necessarily that it is mishandling by audiologists, but simply that our judgment might be a little different today than it was a few years ago. Everyone makes errors in judgment, but audiologists do not overtest as dealers oversell.

I hesitate to comment at great length about this memo. I do not want to divide the camps totally, but this strikes me as a bugle call of some sort on the part of the industry.

Mr. ORIOL. Just to editorialize for a moment, we certainly hope the conflict between audiologists and hearing aid dealers does not become a fixed part of the scene.

I have no other questions for Dr. Resnick, Senator Fong.

Senator FONG. Doctor, as far as you know, do you think the hearing aids now manufactured are sufficient to take care of the hearing needs?

Dr. RESNICK. You are talking now about the 50 manufacturers, that is the number of hearing aids?

Senator FONG. Yes.

Dr. RESNICK. I would think that with something in excess of 350 models, the field is probably overcrowded.

There probably is no other appliance that the consumer purchases where he has such a wide choice.

If you go to buy a refrigerator or television set or even an automobile, you do not select from 300 plus different models, and this may be in part the reason why we are in conflict in terms of pricing in this industry. Overproduction.

Senator FONG. As far as the instrument is concerned, it is adequate?

Dr. RESNICK. Yes. But it can be improved.

Senator FONG. Are prices competitive?

HEARING AID DISCOUNTS

Dr. RESNICK. Well, I think prices certainly are competitive; that is, alike, but when you take into consideration that there are organizations such as Master Plan, such as Behavioral Prosthetics, such as an organization in Chicago called Paid, and other dealers springing up here and there willing to sell discount hearing aids, there is the hint of profit-cutting to beat the competition. The answer to your question is, yes, prices are generally competitive, but I have the feeling that what you are asking is are the prices unreasonable, higher than they should be.

My feeling there, of course, is that prices are too high, that the consumer, particularly the elderly, cannot obtain instruments when they need them, predominantly because of the cost.

Senator FONG. Cost is high because of sale to the individual rather than wholesale?

Dr. RESNICK. Certainly there are advantages to bulk purchases.

I do not think the cost is high because dealers come to the individual.

The industry probably can testify to this certainly better than I can, but I would personally judge, and this is my own opinion, that most new hearing aids sold by dealers are not sold in offices, they are sold in the home.

Senator FONG. That adds to the cost?

Dr. RESNICK. Well, that might add to the overhead of the salesman.

I do not know, but it would seem that maintaining an outside and inside sales force would add to the cost. That certainly is a part of overhead built into the sales price.

Senator FONG. Now, the indictment against the business of hearing aids is delivery, is it not, delivery of service?

Is that where the criticism is—where the aid does not really fit a person?

Dr. RESNICK. That is right. I do not think the delivery of service, or of the instrument is adequate.

The decision as to the need for, and benefit derived from, a hearing aid has been left largely in the hands of people not fully qualified to make the decision because of product conflict. Hearing aids and hearing services should be dispensed on professional recommendation only. As the panel from Ralph Nader's office alluded to, this will require a large public education program, and solid professional management of this problem. It is a fine recommendation.

Senator FONG. You feel that they should be professionally fitted?

Dr. RESNICK. That is correct. Preferably by audiologists.

Senator FONG. And that there should be a wide choice of the instrument?

Dr. RESNICK. That is correct.

Senator FONG. Thank you.

I have no further questions.

Dr. RESNICK. Thank you.

Senator CHURCH. Dr. Sullivan, please proceed.

STATEMENT OF DR. ROY F. SULLIVAN,* ASSOCIATE PROFESSOR, DEPARTMENT OF SPEECH ARTS AND SPEECH PATHOLOGY/ AUDIOLOGY, ADELPHI UNIVERSITY, GARDEN CITY, N.Y.; AND CONSULTANT, U.S. ENVIRONMENTAL PROTECTION AGENCY, REGION II, NOISE BRANCH

Dr. SULLIVAN. It has been about 5 years since I appeared before this subcommittee to give testimony concerning hearing aids and the elderly. Considering the basic issue of the potential inclusion of prosthetic amplification under the purview of title XVIII, Medicare, I would like to comment on what I perceive to be the most significant developments, relative to the needs of the aging hard-of-hearing consumers, which have occurred in the intervening period of time.

As was the case prior to 1968, I have served these last 5 years as chief of the division of audiology at the Long Island College Hospital in Brooklyn, N.Y.

*See prepared statement, app. 2, item 9, p. 131.

There, we serve the needs of a predominantly geriatric hearing impaired population.

The majority of these patients, in turn, have surgically inoperable, sensory-neural losses of hearing.

My comments pertain specifically to the areas of technological advances in hearing aids, public assistance, and distribution systems.

Before I proceed, may I say that, just prior to leaving home for Washington, my 12-year-old son, Glenn, approached me with a hearing aid joke he had just heard on television. He thought that I might be able to use it here at these hearings.

I put it aside, saying, no, I thought there would be no place for that sort of thing, here.

However, since I heard cited in previous testimony the Public Health Service survey, and the industry's "Market Facts" survey stating high proportions of hearing aid user satisfaction, I feel compelled to pass this story on to you.

The story goes as follows:

Two men meet on the street.

First man: "I feel wonderful."

Second man: "Why do you feel wonderful?"

First man: "Because I just purchased a new hearing aid. It cost me $875. But I love it. I have never heard like this in my life. I have a whole new world of listening opened to me. It is a remarkable instrument. I am truly satisfied with it."

Second man: "What kind is it?"

First man (looking at wristwatch): "4:30."

The moral (it needs hammering home) is that the hard-of-hearing individual is a poor judge of what constitutes a successful hearing aid fitting. What sounds good to the impaired ear may not be providing intelligibility, and the ultimate reason for prosthetic amplification is to open the channels of communication with one's fellow man, which have been closed by hearing loss.

Channels of Communication

If the speech sound is mellow or smooth, but it is not intelligible, the user may be subjectively satisfied. However, this may be an artifact of the sound quality or timbre rather than its intelligibility. So, simply asking whether an individual is satisfied with his hearing aid, provides no objective measure of its effectiveness or of the optimum nature of that particular fitting in the rehabilitation of his hearing communicative disorder.

There could be, for that individual, a great number of better, more effective fittings than that one with which he appears nominally satisfied. Furthermore, in any such survey, the proportion of nonrespondents may provide a more meaningful index of dissatisfaction than those who do reply.

To go on to technical advances in hearing aids:

There were a number of comments in the 1968 record concerning the eventuality of any major technological breakthroughs in the hearing aid field in the next 5 years.

The comments, by and large, at least from the public health services sector, were negative.

For me, as a professional audiologist, working in this field for 13 years, mostly with older people—I think that these last 5 years have comprised the most critical period in adjusting the technology of prosthetic amplification to the needs of the very population which we wish to serve under Medicare.

I have never felt more confident as a professional than at the present time in my ability to propose a reasonable alternative to the needs of an elderly hard-of-hearing patient who comes to me admitting a hearing problem. This admission, incidentally, is the first and most important step on the road to being successfully rehabilitated back into a hearing society. During these particular 5 years, the technological advances have come about, because of the work of the hearing aid industry, in all its allied areas, and the profession of audiology. I must define the hearing aid industry as not merely consisting of aid manufacturers, but also of the companies that make the transducers, microphones, that take in sound and convert it to electrical energy, and receivers that take the amplified electrical energy and convert it back to sound—the component parts—the batteries and earmolds. We also have to cite the contribution of the manufacturers of packaged integrated circuits. Because of this "outside" technological spinoff, the hearing aid industry, if it chooses, may select standard prepackaged mass-produced integrated circuits which should cause the cost of hearing aid manufacture to be far less than it has ever been before.

It is interesting to note that, in many respects, the hearing aid industry and computer industry share a common technology.

The hearing aid industry recently circulated a chart indicating that, over a 1955 base, hospital costs have grown on the order of 246 percent, while hearing aids have only risen on the order of 23 percent. I imagine we should be thankful for small blessings.

On the other hand, prices of computers, in the same period, have actually fallen by 75 to 90 percent. For example, the present-day typical list price of a hearing aid, a simple microphone-amplifier-receiver combination, at $395, will purchase an H-P 45 pocket calculator that will perform all mathematical functions of an instrument which, only 5 years ago, cost upward of $2,000.

Rise in Wholesale Cost

It is interesting to note that, even though a parallel technology is shared, there is still a rise in the cost of wholesale hearing aid prices while computer prices fall.

As stated in my introduction by Mr. Oriol, I have presently joined the faculty of Adelphi University. In addition, upon my return to New York, I will also serve as consultant to the U.S. Environmental Protection Agency, Region II, Noise Branch. In my prior tenure on the New York Mayor's Task Force on Noise Control, we visited one of the large manufacturers of jet aircraft engines. We were told by this manufacturer of jet engines, when we asked when we could expect jet engines to get quieter, that we should be thankful they are only getting noisier at the rate of 1 decibel per year.

They used to get noisier at a faster rate than that. This aside is by way of analogy with the wholesale and retail prices of hearing aids.

Senator CHURCH. Do you have any reason to believe an increase in noise levels would have a special impact on older persons?

Dr. SULLIVAN. As far as the likelihood of increased geriatric susceptibility to noise-induced hearing damage goes, this relationship has yet to be scientifically verified. With regard to arousal from sleep, persons over 60 have been shown to be aroused by noise much more easily than younger adults or children. From a psychological point of view, there is, for want of a better word, a certain rigidity characteristic of the elderly individual, which makes him relatively accepting of an unchanging or slowly changing environment. An elderly individual, brought up in a noisy neighborhood with a slow but steady increase in the rate of noise growth over the years, may accept that growth.

On the other hand, if an elderly individual who has always lived in a quiet neighborhood is suddenly confronted with noise in his environment, he will be personally more inflexible toward the acceptance of that noise or the infraction of his "auditory life space" than a younger person.

To continue about the hearing aid technology: We have to acknowledge the contributions of Bell Laboratories. Although they are not members of HAIC, their developments of the transistor, the integrated circuit, and most recently the electret microphone, have revolutionized the industry. We also have to credit the profession of audiology with the evaluation of these advances, and also for coming up with, perhaps, the most important advance in hearing aid technology of particular significance to the geriatric consumer; that is, the open mold fitting, pioneered by Harford and Barry, two audiologists at Northwestern University.

Integrated circuits, comprising the amplifier section of hearing aids, have reached a high level of development and mass production under the impetus of demands from the computer and aerospace fields. In some cases it becomes more economical to simply remove the entire malfunctioning electronics from a hearing aid, discard it, and replace it, rather than "troubleshoot" it and replace a single defective resistor or transistor.

A number of instruments of American manufacture incorporate plug-in components.

So when a hearing aid user returns a damaged or defective aid for so-called service—mechanical service, being a bona fide service a dealer offers—the dealer is able to immediately effect a repair by pulling out the "guts" of the hearing aid, plugging in another set, and then determining, after the fact, if it should be repaired or discarded. Due to integrated circuits, the size and weight of eyeglass type [demonstrates] and behind-the-ear type aids [demonstrates] have decreased, while the amount of effective amplification provided by these respective units have increased to the 60-decibel range. Five years ago, this amount of gain could only be achieved with a body-type instrument [demonstrates].

Now, we can fit 80 to 85 decibel losses of hearing with ear level hearing aids having gain in excess of 60 decibels.

This means that the potential geriatric hearing aid user who rejected the concept of amplification 5 years ago—because he would have been forced to wear a body-type hearing aid, which would have had to be clipped in an inner garment or to a pocket—is now very likely to join the large population of head-borne hearing aid users. That is, he could wear an ear-level aid where the microphone and all other parts are located approximately at the level of the ear. Thus, one of the larger social stigmas to fitting the more severe to profound losses of the geriatric patient has been removed because of integrated circuit technology.

Senator FONG. Is that the entire instrument, in back of the ear [indicating an eyeglass-type hearing aid]?

Dr. SULLIVAN. This is not, no.

Senator FONG. Is that the entire instrument [indicating a behind-the-hear aid]?

Dr. SULLIVAN. Yes.

This is the entire instrument [demonstrates].

It consists, in its major parts, of a microphone, which is located down here at this little hole, a receiver which is located up here, which transmits the sound to the ear mold, which is located in the ear. The amplifier is inside, and the power supply is located here, a battery about the size of a half a pea. Despite its miniature appearance, when properly fitted, it does, I must say, a most effective job. Some hearing aids have a number of tone or output controls, but all of them have a gain control functioning essentially the same way as a volume control on a television or high fidelity set.

Senator FONG. How long would the power remain?

Dr. SULLIVAN. The power on this would probably last 1 to 2 weeks, depending on how many hours per day it is used.

This is a mild gain, open mold, behind-the-ear aid, so the individual who is appropriately fitted with it would not be constrained to wear it 16 hours a day as would be those who wear more powerful body aids.

As the severity of the hearing loss increases, the total dependency on having all sounds pass through amplification becomes greater.

An aid of this kind [demonstrates behind-the-ear, open mold aid] would be fitted to an individual who experiences great difficulty with soft conversational speech and perhaps little difficulty with average conversational speech.

So integrated circuits have been a boon for the geriatric hearing-impaired consumer.

In the last 5 years, we have seen some dramatic advances heralded in hearing aid industry advertising.

Most of these advances have really not been developed by the hearing aid manufacturer, per se, that is, the individual who stamps his name on the finished product, so much as they have originated with the transducer manufacturer. So, you will see advertisements for a new ceramic microphone, a new electret microphone, or a new directional microphone.

These are innovations, forward steps, I might add, which are developed by the transducer manufacturers.

There are about two or three major transducer manufacturers, Knowles, Tibbetts, there are others who supply virtually all, or I would say the vast majority, of hearing aid manufacturers with the most critical components: microphones and receivers. So, while the cost of these developments is passed on to the manufacturer and, ultimately, to the consumer, most of the credit taken by the hearing aid manufacturer for recent advances, really should be shared by the transducer manufacturers. Although ceramic microphones were available at the time of the last hearing, their use in subsequent years has become widespread. It has a broader, more extended frequency response.

Electret Microphone—Recent Innovation

The electret microphone, developed at Bell Laboratories, is a recent innovation in hearing aids. It has a very low effective mass which makes it relatively impervious to shock and vibration.

One of the most common causes of damage to a hearing aid is the fact it is dropped or jarred. The input and output transducers, particularly the microphone, are highly susceptible to damage.

This electret device has a very, very low mass, wide frequency range, relative to other types, and a good response to sharp or transient sounds.

The third recent transducer advance is the directional microphone.

In 1968 there were claims of directional microphones, and I would venture that 10 or 20 years ago we had industry claims of directional microphones. However, studies (one of the most interesting of which comes from the industry itself) indicated that these so-called frontal microphones, which were simply pointed forward with a little acoustic snorkel, provided little more than a decibel of directionality.

Today, a new rear port directional microphone has been developed. Whether it originated with a German company, Willco, or whether it originated with an American company, Knowles, is uncertain. This particular device is a dramatic advance, and permits an aided individual, in certain specific noisy situations, to function more effectively than a normally hearing unaided individual.

Specifically, it will provide as much as 20 decibels isolation from a sound originating in the rear with reference to a sound coming from the front.

This seems, at initial glance, to be attractive.

We have tried to recommend it to our patients, both elderly and younger age groups, with hearing loss.

In some cases, we have had success. In other cases not.

One of the major problems we have encountered is that the directionally aided individual now has to acoustically periscope his field because of the high degree of directionality. However, technological compromises can be anticipated in this area.

With regard to the geriatric hard-of-hearing patient, I feel that the most important technological advance, whose development is attributable to the field of audiology, is the open- or no-mold hearing aid fitting (CROS and IROS).

Senator Church. Doctor, we are running out of time; in fairness to the industry, I want to give them an opportunity to be heard this after-

noon, and I am wondering if you might summarize your remarks and include the full statement in the hearing record.*

Dr. SULLIVAN. Yes, sir.

The open mold principle in my opinion is the most significant advance for the geriatric consumer of hearing aids.

Where we were fitting less than 13 percent of our hearing aids with open molds in 1968, we are now fitting 75 percent of our geriatric patients, and I might say objectively successfully, in this manner.

HEARING AIDS UNDER MEDICARE

We have measurable criteria, audiological criteria, other than a verbal survey of user satisfaction, to determine that these people have been successfully fitted. To summarize on the issue of technology, in my opinion, the technology is right for the inclusion of the hearing aids under the purview of Medicare.

What about the issue of expenses to the elderly consumer?

In my written statement, I present some statistics which are derived from industry sources.

They cite about 7½ million potential candidates for hearing aid use. One can probably extrapolate that 3.75 million of those candidates, out there waiting to be fitted, are over 65. They are senior citizens, and would be eligible for Medicare.

Estimating a distribution price for each fitting at about $300, including a 20- to 25-percent discount for a Government subsidized program, as is given in many States today, the expenditure would be on the order of $1 billion to fit those additional 3.75 million with aidable hearing losses over the age of 65.

Dr. Resnick has indicated that other, economically more effective, hearing aid distribution systems are beginning to develop. These systems must be given a fair trial as a potential compromise between the existing unsatisfactory system and a socialized, European type distribution system.

Dr. Loavenbruck indicated earlier that initially the New York State Medicaid program was allowed only a 20-percent discount toward the State purchase of hearing aids. Mrs. Shapiro, director of the bureau of economic analysis, New York State Department of Health, will comment tomorrow on the fact that, due to her efforts, no hearing aid presently costs the State of New York any more than $235. I might comment at this point that there are no dealers in the State of New York who are reported to be boycotting the Medicaid system, even though that price is significantly below the typical $350–$400 manufacturer's suggested retail price.

The last and most important issue to be aired is that of the present retail hearing aid distribution system.

My major quarrel is with its basic premise in operation.

The entire justifications of markup by the retail dealer is based on an economic egg shell.

The faulty assumption simply has to do with low volume of sales justifying a large markup, to the exclusion of high volume/low markup systems. With 600,000 aids sold annually by 6,000 dealers, you have 100 aids per dealer, which comes out a little less than 10 per month,

*See appendix 2, item 9, p. 131.

and that is something like 2 per week. We are told that the dealer has to pay his rent and other operating expenses, thereby justifying a 200 percent to 300 percent markup on a purely statistical basis.

The entire economic logic of this industry is internally consistent, not efficient, but consistent. The only way one can shatter that "eggshell" is by determining if, in fact, there are other effective ways to distribute hearing aids, and the answer is yes.

A classic example is the Veterans' Administration system which has reduced the effective cost of dispensing hearing aids, including evaluations, down to slightly more than $200. We hear much about the service which the dealer offers.

Servicing of Product

I am interested in a hearing aid dealer providing a product, and in servicing that product in the same way that an optician would provide a product and service that product on prescription from a nondispensing optometrist or an ophthalmologist.

I have no need of these so-called services which the dealer—essentially a 90-day wonder—purports to supply. These include the testing and measurement of hearing, testing of air-bone gaps, testing of auditory speech discrimination and social adequacy, psychological counseling, and rehabilitation. These are areas which have taken people, qualified audiologists in the field, years of study and professionally supervised experience to obtain a reasonable degree of competency.

With only a hearing aid society correspondence course, and sales experience, how can we justify the fact that hearing aid dealers at the retail level can offer rehabilitative and counseling services? I can cite instances from hearing aid trade journals, where it is suggested that dealers charge $7 to $8 for a "rehabilitation call," and $20 for an "audiometric test." This reference was part of an industry survey to determine whether retail dealers would like to break down their product and service charges into two separate categories.

In that survey, which was done at the end of 1971, 55 percent of the dealers indicated they were opposed to a fee-for-service concept.

Thirty-four percent approved, and 11 percent were not sure about separating service and product.

The problem with aid pricing is that we are paying for the product and pseudoprofessional services, whether we need them or not.

My professional demands from a hearing aid dealer have only to do with the product and direct mechanical servicing of that product.

To conclude, I would like to read my specific recommendations; the justification of these recommendations is in my prepared statement.

Recommendations

(1) The FTC must vigorously pursue its case to discourage the hearing aid industry from its limited distribution practices and its suggested retail pricing practices.

In order for free competition to prevail—the possibility of high volume, low markup systems, such as Master Plan and Behavioral Prosthetics—for any of these high volume operations to succeed, they must have the freedom to secure instruments from manufacturers at

the same wholesale prices as are available to other dealers. The reason they cannot succeed at the present time is because sanctions are being brought to bear by traditional dealers against manufacturers who cooperate with these programs. This is why Master Plan System is down to one brand of hearing aid.

I personally could not work with a single brand of aid. However, if Master Plan did open a branch in New York with a reasonable variety of hearing aids, anywhere near the number offered by Veterans' Administration, I would be happy to send them all of my professional referrals. They will follow my instructions to the letter, take earmold impressions, mechanically fit the aid to the external ear, and then provide mechanical service as it is indicated.

Unless the FTC cases against industry practices are pursued, prosecuted, and successfully terminated, there is no possibility of an alternative to the old "Edsel" system—there is no possibility that this inefficient system could ever be replaced. So it is of the highest importance that this FTC case succeed.

Now the second recommendation:

(2) With a physician's referral, professional audiologists should be permitted to offer their traditional hearing aid related services to the elderly hearing-impaired individual under title XVIII (Medicare). These services, now proscribed, should include, but not necessarily be limited to, hearing evaluations, hearing aid selection and evaluation, counseling and hearing therapy.

If the geriatric patient has the desire to seek trained, qualified, professional advice on which hearing aid he should use and how he should use it, he should be free to do so under Medicare.

He cannot at the present time.

Ban on Advertising

Third recommendation:

(3) Brand name advertising of hearing aids, in other than hearing-related media, should be banned. Public relations programs such as the hearing aid industry's Better Hearing Institute might represent a more efficient pooling of capital resources to truly educate the hard-of-hearing to the issue of hearing health care.

One of the largest segments of industry cost is related to the advertising of hearing aids in public media.

All of the advertising money could be put into a "kitty," for example, the Better Hearing Institute. If in fact their goal is truly to inform the hearing-impaired public that there is an alternative to deafness, to loss of communication, then let them pool their resources without setting up petty competition between brands, and causing diffraction of economic and technical resources.

The fourth recommendation:

(4) The Government must undertake, under Medicare, a number of large-scale demonstration projects to test several modes of hearing aid delivery systems compatible with the needs of the geriatric hearing-impaired consumer.

I am not in a position at this point to come out and say we must apply the Veterans' Administration's system to Medicare.

I think we must give credit to the fact that hearing aid dealers were the first to sell hearing aids.

At the beginning they sold hearing aids.

At the present time, I feel they should sell hearing aids, but not masquerade as professionals.

They are a commercial enterprise distributing their product to the hard-of-hearing community. I think they should be given a chance to survive in an open market, in a fair economic arena. However, the only way this economic state of free competition can be achieved is if the limitations by industry of distribution practices are broken by the Federal Trade Commission.

I would like to see every dealer in New York City drop his prices to $200, or below, and I would be very happy to patronize free enterprise rather than to go into a system where we are wiping out competition under Government subsidy.

Senator CHURCH. Thank you very much, Dr. Sullivan.

I have one question for you.

NEW TELEPHONE DEVELOPMENT

I understand that in the name of technological progress, the A.T. & T. is developing a new telephone.

With this new phone many deaf people will not be able to hear; is that correct?

Dr. SULLIVAN. Yes, sir.

In 1966 the Bell Laboratories served notice on the hearing aid industry—I think the history will be developed by Mrs. Knauer tomorrow—that they were going to take their particular telephone receiver which radiated a rather large magnetic field, and they were going to make it more efficient.

Senator CHURCH. They are going to make it more efficient by designing it in such a way that deaf people will not be able to hear over it?

Dr. SULLIVAN. Well, efficiency in a physical system is defined by the proportion of input energy to output energy.

Senator CHURCH. I am defining it in an old fashion way, human terms.

We have a lot of deaf people using telephones.

Is the A.T. & T. really going to replace that kind of telephone for the new one?

Dr. SULLIVAN. Yes, sir.

It will make it difficult for many of them to hear, but not impossible. However, for a large proportion of the hearing impaired population, who use body-type hearing aids, it will make it impossible.

Senator CHURCH. Don't you think that is just plain stupidity?

Dr. SULLIVAN. Progress in many instances seems stupid at first.

There are, I believe, alternatives. As the present hearing aid distribution system has been founded on a faulty economic premise, the present method of tying the deaf into a telephone system is founded on a faulty electronic premise.

Senator CHURCH. But it works, does it not?

Dr. SULLIVAN. It works, yes, but all of that magnetic leakage coming out of the telephone is inefficient.

Senator CHURCH. Inefficient in what sense?

Dr. SULLIVAN. That electrical energy is being wasted in magnetic energy.

I am not a spokesman for the telephone industry and I am not going to tell you your phone bill is going to go down because of the recouped magnetic energy.

I would suggest you convene a working panel up here of people from the phone company and the hearing aid industry to hammer out their differences and reassign fairly the appropriate responsibilities in this matter.

Senator CHURCH. Will you make a demonstration that would indicate to us, do you have the new telephone here?

Dr. SULLIVAN. I have the new telephone here.

Senator CHURCH. Will you tell me what needs to be done with the new telephone to enable people to hear over it?

Dr. SULLIVAN. It is very simple.

Hearing aids have, in the past, been coupled with the telephone by a magnetic field.

There never was any physical contact between the hearing aid, and the telephone.

The telephone company would not permit any other, more direct form of linkage with a hearing aid.

The hearing aid companies developed a means of using that magnetic leakage with an inductive pickup in their product.

Now, the telephone company wants to improve its product, and they have come up with an alternative which is really unacceptable.

This is the "hockey puck," a device which the person would have to carry around. It runs on batteries and straps to the telephone earpiece. It is an acoustic-to-magnetic converter that takes the sound, converts it to a magnetic field, and then you can use it through the standard hearing aid with an inductive pickup.

This is the telephone company's answer to the problem.

They make no changes in their product.

The hearing aid industry makes no changes in its product, and the hearing aid consumer is in the middle and gets stuck.

Senator CHURCH. That is par for the course.

Dr. SULLIVAN. That is par for the course.

Senator CHURCH. Why cannot the A.T. & T., with all of its expertise, design a telephone that many people can use at least as handily as the present telephone?

Dr. SULLIVAN. Probably because it costs money.

That particular question could best be answered by the telephone industry.

I am not their spokesman, not their advocate.

In this particular issue, I am against it.

ALTERNATIVES TO "HOCKEY PUCK" CONVERTER

In the course of preparation for these hearings, we have come up with an idea which was implemented through the cooperation of Mr. Josh Gendel who is the chief electronics engineer for the New York League for the Hard of Hearing. It is simply one of a number of possible alternatives to the "hockey puck" converter.

According to some fairly recent rulings, a telephone subscriber may plug his own telephone into his own home system, provided by the phone company. Why, then, can't you take a hearing aid and plug it

into a telephone? We came up with a simple inexpensive device which a hearing impaired user could plug directly into a telephone and fare far better in listening than he would if he were using the existing coil method.

If I may demonstrate.

Now, normally for a telephone user, the body hearing aid is worn here, in the pocket, or it is worn attached to an undergarment. When the body hearing aid user wants to use the telephone, he has to invert the handpiece and talk into it this way. He has to speak into the handpiece upside down, and he has to bring the receiver or earpiece in the vicinity of the coil inside of the hearing aid located on the chest. There is no physical contact.

Senator CHURCH. What if the person is wearing a hearing aid in the ear? Could he simply put the phone up to his ear and use it that way?

Dr. SULLIVAN. No, he could not—not with the new phones.

Acoustically there would be a vast drop in loudness and intelligibility. Some ear-level hearing aids have a telephone coil built in, but they would be unusable with the new phone. With the older phone, the ear-level hearing aid wearer had to talk out of the side of the mouth in order to line the earpiece up with the hearing aid coil located at the top of the pinna, here [indicating].

If he uses one of these "hockey pucks" he really has to talk out the side of his mouth, this way [demonstrating "hockey puck" coupler].

[Demonstration of direct electrical link of hearing aid to the new telephone.]

[This is a recorded message from the New Senate Office Building telephone operator.]

Now, that is relatively soft.

The volume control of the hearing aid turned up all the way. There is not enough magnetic energy radiated from this new telephone to satisfactorily use this hearing aid.

This is a powerful body aid, and a person with a severe or profound loss of hearing would not be able to hear that particular message using the existing coil pickup and the weak field coming through the particular hearing aid.

Now, what we have done is developed a very simple resistive network.

Senator CHURCH. This is the new telephone you are showing?

Dr. SULLIVAN. This is the new telephone with the reduced magnetic field.

We developed a simple resistive network, which consists of 5 cents worth of resistors that allows the individual to plug his hearing aid directly into the system.

Now, I have not changed the volume setting.

Here comes our operator again. [Operator comes on again.]

The immediate problem with this simulated demonstration is that the hearing room microphone was not designed to be sealed in this manner, to allow us to play the hearing aid sound through the house public address system. However, we pick up in the ear, an additional 30 to 45 decibels of loudness, once we plug directly into the telephone.

The clarity is greater than it was before.

This particular approach would obviate the necessity for the hearing aid user to be charged the extra amount that most manufacturers charge for the coil.

It uses an internationally standardized hearing aid polarized plug, and it is not susceptible to a fluorescent field or neon ballast.

Hard-of-Hearing Obstacles

If the individual goes into a phone booth where there is a fluorescent light, there is a chance for the ballast transformer which radiates a hum, to be picked up by the hearing aid. This noise may be more annoying to the hard-of-hearing individual than any of the surrounding sounds. This is not the case with a direct electrical connection.

It will require cooperation from the hearing aid industry to make the plug-in jacks accessible. It will require cooperation from the telephone company to put about 10 cents worth of parts into each public telephone or private telephone where it was requested. There would be no need for the hard-of-hearing body aid user to have his suit custom made, to have a special pocket built in to carry around the battery-powered "hockey puck" converter.

We have developed this simple alternative. It is merely one of a number of possible ways to surmount this additional obstacle presented to the hard-of-hearing public. It is public domain, and it is open for anybody who would like to explore it.

We have tentatively discussed this matter with the telephone company, and it is only fair to say they are considering it.

Senator Church. It is just a horror story to me, the whole thing.

The scientific way seems to be some wrong with the directions in this country, that nothing is designed with the needs of the elderly or handicapped.

It is true of our transportation, of our buses, and now it is going to be true of our telephone, and this is done in the name of progress.

People are last considerations, and among the people the handicapped are at the bottom of the totem pole.

Our next witness is Mr. Anthony DiRocco, executive secretary of the National Hearing Aid Society, and he is accompanied by Marvin H. Pigg, Esther Daniel, Joseph Lucke, Raymond Z. Rich, and Richard Kitch.

Mr. DiRocco, you may introduce the members of the panel as they are seated, and proceed as you wish.

STATEMENT OF ANTHONY DiROCCO, EXECUTIVE SECRETARY OF THE NATIONAL HEARING AID SOCIETY, ACCOMPANIED BY MARVIN H. PIGG, PRESIDENT; ESTHER DANIEL, VICE PRESIDENT; JOSEPH LUCKE, PAST PRESIDENT AND GOVERNOR-AT-LARGE; RAYMOND Z. RICH, GOVERNOR AND LEGISLATIVE CHAIRMAN; AND RICHARD KITCH, COUNSEL

Mr. DiRocco. Thank you, Senator Church.

On my far right, we have our legal counsel, Richard Kitch. This is Mr. Rich and Mr. Pigg.

Mr. Pigg will give our presentation.

Mr. Pigg. Thank you.

Senator Church and members of the committee, I have also behind me Esther Daniel, the vice president from California; and the immediate past president from Florida, Mr. Joseph Lucke.

We have approximately a 30- or 35-minute presentation.

I am going to leave it up to you if you want to work late.

Senator CHURCH. We will give you as much time as necessary for a full presentation of your case.

Mr. PIGG. I would prefer to take it as it is, if you will.

We are pleased to come before your committee today to assist you in your assessment of the hearing aid delivery system, and to provide information which may be helpful to you in your deliberations about whether to include hearing aids under the Medicare program.

I am Marvin Pigg, president of the National Hearing Aid Society, and I am accompanied by Anthony Di Rocco, our executive secretary, and our legal counsel, Richard A. Kitch.

Also, we have with us 3 officers of our association, which has over 3,400 hearing aid specialists as members.

They are Esther Daniel, our vice president from California; Joseph Lucke, past president and governor-at-large, from Florida; and Raymond Rich, our legislative chairman and a past president, from Ohio.

We have two principal areas of concern which both we and the American public need to have aired.

This subcommittee hearing is par excellence the appropriate forum in which to explore both these areas.

The first area concerns our association's proposal for the best way by which the Government can assist persons qualified for Medicare to receive the help they need for a hearing impairment. The second area concerns our association's response to the largely misguided, wrong-headed proposals made by Mr. Nader, his associates, and others regarding a radical change in the way hearing aids are dispensed to those who need them.

The two areas are interrelated, as will become evident from our testimony, but we prefer to begin with the first because it is positive and offers a major step forward toward better care for the elderly and some important savings for the American taxpayer. The second portion of our testimony will answer the erroneous and in some cases malicious criticism from people who either do not understand in depth the unique problems of the hearing impaired or who, in some cases, have a selfish financial interest they are eager to advance, even at the expense of the hearing impaired and the taxpayer.

HEARING AID DELIVERY SYSTEM

Mr. Chairman, the present hearing aid delivery system has been tested and refined over a period of 50 years or more. Of the approximately half a million people who acquire hearing aids every year, about 98 percent have benefited from the services of a hearing aid specialist. We perform a necessary and valuable service. From the standpoint of time and manpower alone, it is a service which neither the medical profession nor the clinical audiologists can render. This is inherent in the nature of things. Let me quote briefly from a letter to one of our society officers from Dr. Aram Glorig, the prominent otol-

ogist and director of the Callier Hearing and Speech Center in Dallas, Tex.:

> The task of delivering otoaudiologic health care demands the use of a comprehensive health team. The most active and best suited members of this team are the otologist, the audiologist and the hearing aid specialist. Each has his own position on the team but each must realize the task is best completed when the three members perform as a team. The task is too large and complex to be accomplished in any other way.

Dr. Glorig goes on to describe the function of the ear physician and how it came about that a role developed for the nonmedical professional; that is, the audiologist.

He then states that the nonmedical professional—and I quote—"Cannot handle the servicing aspects of hearing aid wearing and maintenance as well as the hearing aid specialist. This means the hearing aid specialist is essential to deliver and maintain the aid."

I am submitting the entire text of Dr. Glorig's letter for the record.*

There are problems. We know that one of the biggest hurdles we encounter is to motivate the hearing impaired to obtain help. Generally, they have a strong resistance to admitting their handicap, and especially, to wearing a prosthetic device. All studies show that the hearing aid specialists have been prime motivators. And they have done much more. They have provided skill, service, encouragement, and compassion. And, as objective studies prove, the consumers are pleased with what they have done.

Expansion of Hearing Aid Services for Elderly

We heartily endorse the concept of making the benefits of hearing aids more readily available to the elderly hearing impaired. The National Hearing Aid Society supports and encourages the enactment of legislation designed to provide assistance from public funds for hearing aid procurement and related services for the elderly who qualify for Medicare, providing certain criteria are met:

(1) That maximum competence be assured in the testing, selection, fitting and post-fitting instruction and counseling, to promote maximum satisfactory services and adjustment to hearing aid use. This can be done only if a hearing aid specialist is utilized in every transaction.

(2) That any plan adopted utilize the public funds in a manner which achieves maximum benefits at lowest possible cost; that the interests of the taxpayers be appropriately considered by making maximum use of the established and successful delivery system now available through private enterprise, and avoid the establishment of elaborate, overlapping, and costly Government machinery for administering the programs. In determining costs to Medicare or any other Government program, all costs should be included—not only the cost of the hearing instrument and the salaries of the personnel in the dispensing centers, but the costs of the central administration, the building costs and maintenance, lighting, telephone, and other overhead, the cost of printing and distributing informational literature, forms and letterhead, processing refund checks, and the dozens of other hidden costs necessary to running an efficient operation. Then

*See appendix 2, item 10, p. 134.

compare this total cost to the Government with the hearing aid dealer's retail price.

(3) That any means utilized will appropriately recognize the special problems of the aging, such as chronic infirmities which decrease mobility, transportation problems, and financial problems, and create a system which offers maximum convenience, and a minimum strain in obtaining care.

We believe that these benefits are now largely available through the present private delivery system, which, with some minor modifications, can readily be mobilized for even greater service to our hearing-impaired elderly.

We are submitting today the National Hearing Aid Society's "Plan for Hearing Aid Procurement Under Medicare."* To save your time, I will just touch on the main points of the plan:

Rather than create still one more bureaucratic structure, we propose to use the full strengths of the existing hearing health team—the otologist, audiologist, and hearing aid specialist—in their communities.

When a hearing aid is indicated, it will be described generically rather than by brand name.

Our plan gives the client maximum freedom of choice, consonant with the objective of assuring that he or she receives the best possible help for the particular hearing problem.

Finally, our plan assures Medicare of the most economical way of fitting qualified persons with a hearing aid, based on an assessment of all the costs—including the hidden overhead costs and the costs of services before and after the client receives a hearing aid.

The essential elements of this plan have been in use in California under the State's Medi-Cal plan long enough to prove its validity. We believe that you can adopt it with confidence.

Real Issues Obscured

Regarding our second area of concern—the brickbats and misinformation which have been hurting both our society members and the hearing-impaired population of this country—I would like to explode at least the major misconceptions and false charges.

Now, on the basis of the smokescreen which has been raised by our critics, to obscure the real issues, alternative delivery systems are being proposed to overcome the alleged abuses of the present one. For example, some clinical audiologists are declaring that they, after all, are the only ones really qualified to sell and dispense hearing aids, and cite their university training as a qualification. But, let us examine this carefully. Academic training alone does not automatically qualify a person to test hearing, select and fit a hearing aid, and provide post-fitting care, counseling, and instruction. We have studied the curriculum for audiologists at the University of Michigan, and nowhere in the curriculum does it show a course or a practicum in hearing aid selection and fitting.

Giving them the benefit of a doubt, we may assume that this subject may be incorporated into other parts of the curriculum. But many respected leaders in the field of clinical audiology, such as the late

*See appendix 2, item 11, p. 138; see also appendix 3, p. 168.

Donald M. Markle, Ph. D., chief of audiology at the Mt. Carmel Guild Diagnostic Center, have stated forthrightly that while a few audiologists may have obtained training about hearing aids as comprehensive as the hearing aid specialists have, most clinical audiologists do not have this expertise. Here is some commentary by Dr. William Hardy, Ph. D., a Baltimore audiologist, published in the Journal of the American Speech and Hearing Association:

> Most of our colleagues know relatively little about hearing aids. I doubt that many centers maintain an electronic checkout on the aids they receive or are in some way committed to. I know that the maintenance in a clinical center of the kinds of personnel for purposes of technical checkout of aids and of financial accountability, as well as maintenance of all necessary services, would be prohibitive in cost—and quite unnecessary. To charge this to the patient in the name of service, is scarcely that.

And from John Cooper, Ph. D., an audiologist and assistant professor at the University of Texas Medical School at San Antonio, we have this comment: His school's department of physical medicine and rehabilitation "feels that a hearing aid dealer is in a better position to select an appropriate instrument from the many available models and make appropriate tone and earmold adjustments." Further documentation of this is contained in a supporting paper, presented for the record.*

Senator CHURCH. Let me ask at this point, from some of the earlier testimony you heard——

Mr. PIGG. I did not hear the testimony. I did not listen because I wanted no emotion in my presentation, but I will try my best.

Senator CHURCH. All right.

Some of the earlier testimony referred to audiologists, professional people, as well as from the original panelists today, there seems to be a consensus among them before a person buys a hearing aid, it is advisable for him to have an examination by a specialist, or I take it at least by a physician, if a specialist were not available. When I get my eye examination, I am examined by a professional for eyeglasses, who then prescribes a lens, I take my prescription to an optician, and the glasses are ground, and they are fitted on me, and so forth, and the system seems to work very well.

PRESCRIPTION FOR HEARING AID

Would you have any objection to a State law that would require a prescription from a physician for a hearing aid, and the dealer then would serve as the optician and now serves to furnish the aid, to fit the aid, and do the craftsman's work for which he is experienced?

Mr. PIGG. You must have read my script, because further down we explain this.

In the first place, someone in the Public Health Service said a hearing aid could not be prescribed as glasses are.

We believe this is true today. Furthermore, I do not really think a physician can see all of the people whom we see to take care of this area that you are talking about.

Further down in the testimony, you will find that others have come up with a list of criteria, which is within our realm as nonmedical

*Retained in committee files.

persons to recognize the conditions that should be referred to physicians, so if we get him first, we refer him to a doctor, and when the doctor gets the patient, he then refers him to a hearing specialist if necessary.

Could I go on to this?

Senator CHURCH. Yes, if you will make reference, fine.

Mr. PIGG. Should I proceed?

Senator CHURCH. Yes.

Mr. PIGG. We also believe that the few clinical audiologists who do have such expertise could not possibly provide enough manpower to serve the millions who need hearing aid services. According to the 1973 directory of the American Speech and Hearing Association, there are only 1,972 certified clinical audiologists, and many of these are not available for direct hearing aid services to the hearing handicapped. According to the U.S. Department of Labor, many of these are engaged in teaching, research, therapy, and supervision and administration of clinical programs.

The result, if the clinical audiologists were to assume the role of hearing aid dealers, would be long delays for service, and major inconvenience to all clients, especially the elderly, who might need to travel long distances to reach the hearing centers. This, of course, is the exact opposite of the intentions of your committee—to increase hearing health care services to the elderly. The vast network of hearing aid dealers now in existence can, and is, providing this convenient, local and low-cost assistance which is so desirable and necessary.

Some people say, let the audiologists prescribe the hearing aids, and then have the hearing aid dealers fill the prescriptions.

Mr. Chairman, that suggestion is made only by the misinformed, because hearing aid selection and fitting is an art and not a science.

At this time, hearing aids cannot be prescribed, but must be individually and skillfully fitted.

We cite as one authority an objective researcher, Edith L. R. Corliss, of the National Bureau of Standards, who wrote:

> Hearings aids cannot at present be fitted to individual hearing losses with the same exactitude as glasses can be fitted . . .

Dr. H. Donald Harris, who is described as one of the founders of clinical audiology, and one of the deans of research in that field has made parallel observations. In fact, he said:

> The usual terminal master student (in audiology) knows very little about most of these specialties, and among the things which he knows least about are the difficulties and the multivarious problems of hearing aid fitting. The fitting of an aid to an individual involves a level of understanding of all facets of the instrumentation which the industry affords. And this is not the function of the clinical audiologist. This is the function of the hearing aid dealer who knows his equipment very well.

Our detractors use less than complimentary names at times to describe us. It is important to know that these names are not used by our clients who know us, whom we have served personally and competently. They have indicated solid 90 percent satisfaction levels as measured by reliable polls. The charges against us are made by publicity seekers who want to build their own empires on the solid foundation of the hearing aid industry.

For example, Mr. Nader.

He represents himself as an expert on almost every subject under the sun from atomic energy and automobiles, to Congress, medicine, and cosmetics. Now he has written a hearing aid report, which he evidently intended as an exposé. This report has an interesting history. He commissioned the Retired Professional Action Group to make a study of hearing disabilities and appointed the distinguished Joseph Wiedenmayer as its director. Since he is hearing impaired himself, Mr. Wiedenmayer was determined to prepare an impartial report of genuine benefit to the hearing handicapped. But several obstacles prevented this. One, of course, was that Mr. Nader had said a year earlier that the hearing aid industry is a fraud and he would compile a report to prove it. The pressures on Mr. Wiedenmayer to conform to this policy forced him to resign, and with him, the impartiality which is vital to any research, evaporated.

The tactic which the Nader group is using is a familiar one—isolated instances of abuse are magnified and distorted until the exceptional is made to appear typical.

They take superficial studies, bereft of scientific research methods, and then offer these "studies" to prove conclusions they reached before the study was made.

The Retired Professional Action Group in Baltimore earlier this year turned in an incredibly shoddy report, consisting of brief reports by eight elderly amateur investigators, and amazingly called research. These people were coached to call on about 15 Baltimore hearing aid dealers and ask a series of questions, under the guise of having a hearing impairment. The RPAG group used fake names and later refused to give their real names to the Maryland State licensing board which was trying to investigate the charges. This is the level of reliability and objectivity which characterizes the whole national hearing disability study.

Another notorious report was prepared by a group of Nader-organized students in Minnesota who called themselves the Public Interest Research Group (PIRG).* The sophomoric report was a farce but has been widely quoted to degrade hearing aid specialists. The Detroit Free Press has said of the Michigan PIRG:

> Critics charge that (their report) was weak in research and was a personal vendetta. . . . The report cited specific but uncorroborated instances of violations and used anonymous quotes. . . . County and State health departments said the report was misleading and statistically inaccurate. . . . Few in the media will now print PIRG reports without checking them completely first.

Yet, these reports have disparaged honest people in the name of consumer advocacy. Of even greater concern, the sensationalism and headlines which these reports receive shake the confidence of those millions of elderly hearing impaired people who are already embarrassed to take proper measures to obtain competent care.

Scaring the hearing impaired is not the road to encouraging them. It is the very antithesis of public education. Yes, Mr. Chairman, you should be concerned about the results of these attacks, which damage,

*See summary of MPIRG report, part 2, appendix 3, p. 270.

rather than help, the very people you and your committee and our organization are dedicated to help. We ask, that after your committee has examined the evidence, you will help call a halt to this abuse.

Senator CHURCH. Before we get into the next part of your testimony, let me ask you this question.

On several pages of your testimony, you have been very critical of the Nader investigation.

TRAINING GROUND FOR DEALERS

We had a panel of the Nader people here this afternoon, and if I understood their recommendations correctly, their proposals did not contemplate the elimination of the dealer, generally speaking, and even posed that the business become the training ground for dealers of the future.

This is a far cry from other proposals which would, in effect, eliminate the dealer entirely.

What features of the Nader proposal do you object to?

Mr. PIGG. Mr. Chairman, we have with us our legislative chairman, Mr. Rich, and I believe he can give you a much more in-depth report on that.

Senator CHURCH. The Nader group has proposed what they call a model State statute,* which has been discussed here this afternoon, and in fairness to them, I think you should specify just what it is in their proposals that you object to.

Mr. RICH. At this time, Senator, the report is not completely available to us, so it would be very difficult to comment on it, but the most objectionable part is the trial of an entire group of people, several thousand people, by headline.

There is no doubt about the fact that whatever we say, under no circumstances can match in publicity, or in headlines, the statements of a group such as Mr. Nader has, so this is perhaps the initial reaction to anything of this sort.

The same thing happened in previous instances, like the Baltimore affair, where headlines charged that five normal hearing people and five subnormal people were presented in the office of hearing aid specialists, which later they admitted was not the case, that all, in fact, had subnormal hearing, but the headlines were there, and we are fearful, troubled, and more uncertain about their next action.

I would not go any further into their report which I have not read, but you asked about the legislative part of it.

One of the dedicated practices of our society was, as an independent and free enterprise group of people, to reach out for legislative activity to aid the public, to assure levels of competence which did not exist before, and levels of enforcement or recourse to the public where there is an abuse or any improper activity.

Now, we have some experience with that because in the past 5 years since my last visit here, we have 38 State laws as opposed to six then.

There is such a thing as legislation constructively done or legislation restrictively done.

Senator CHURCH. I do not mean to cut you off, but in answer to my specific question, I think that your president is going to get into a

*See appendix 1, item 1, p. 73.

statement of what you have done historically on the legislative front, but in answer to my specific question, you have not read, and as you say, the report of the Nader group is not yet available to you, is that the case?

Mr. RICH. That is true.

Senator CHURCH. The model State statute is available to you?

Mr. RICH. The model statute is almost in the same category as the report with the exception of the fact that we are more up to date on it, but I will comment at least to answer your question even without some of the specifics.

The model statute has undergone about five, perhaps even more changes.

We have not received it directly but, indirectly we have received copies of it.

I inquired at one time if our input would be desired, and the answer was "No." They said they know our position about it already. So that was it, so it's all behind us. But their model bill is overly restrictive. It is overlegislation in every respect, and we say that on the basis of experience.

One illustration perhaps will suffice. We have heard the story by the panel, their search into dealer activities.

Now, the State of Maryland happens to have a statute, a hearing aid dealer licensing law; but when the licensing board intended to investigate and make use of the already existing law, they received no cooperation. The names (of the shoppers) were not revealed, because evidently the charges would not have stood up. So how can one propose any such legal means that will restrict our law before the present law is even tried out?

That will be a comment on the effects of overlegislation.

Senator CHURCH. Would you like to continue, Mr. Pigg?

CONCERN OVER CONSUMER ABUSES

Mr. PIGG. Since these distortions and exaggerations are given wide publicity, a question which is frequently directed to us, is "How can we control consumer abuses?"

That was one of the major purposes for which our society was founded in 1951. To protect the consumer and our own good reputations, we launched a number of significant programs which have matured over the years and prove their effectiveness.

Let me outline briefly for you what some of these programs are.

First, certification, which was one of our earliest and still very successful and significant programs.

We started certification to encourage hearing aid specialists to reach and maintain high levels of competence and ethics in the selection and fitting of hearing aids. Let me assure you that it is not a paper program, done for sham or show, but a genuine contribution to consumer protection, and we are deadly serious about it. It is granted only to those hearing aid specialists who have met our strict standards of ethics, education, proficiency examination, experience, competence, and character. There is not time to discuss all of these requirements in detail, but I would like to call a few salient points to your attention.

Our educational course has been developed by our education committee with the assistance of Kenneth Berger, Ph. D., and James Delk, M.A., both educators. Dr. Berger, who is director of audiology at Kent State University's School of Speech, notes that:

> The basic home study course is brief insofar as the number of pages it contains; that was purposeful. What many do not realize is that a book on acoustics and two on audiology . . . are required reading. Thus, the course is a digest to which outside readings are required reading.

After completing the course, the student takes an examination which must be proctored by a responsible professional person, such as an educator, a physician, or a lawyer.

To become certified, the applicant must have 2 years of experience in the selection and fitting of hearing aids. He must also swear to abide by our stringent code of ethics, and submit numerous references from persons, including at least one medical doctor, who attest to his competence and character. The qualifications of all candidates are carefully screened by our society, before certification is granted.

When a member becomes certified, he is granted use of the title "certified hearing aid audiologist," which was originated in 1951 by our society.

The word "audiologist" was, in fact, originally used to describe hearing aid dealers as early as 1939. This title is also registered under Federal law. We can document our rights to this title. Yet, our critics would even like to take that away from us, claiming that the public is confused about the differences between hearing aid audiologists and clinical audiologists.

Different Kinds of Specialized Education

This logic is difficult to understand, because in other fields such as engineering, we find acoustical engineers, mechanical engineers, railroad engineers, civil engineers, sanitary engineers, powerplant engineers, nuclear engineers, electrical engineers, and many other types of engineers, all requiring different kinds of specialized education, and the public appears quite capable of making an accurate distinction.

Senator Fong. May I interrupt, since I must leave, and I have read your whole statement.

The dispenser, the man who sells the hearing aid, must be a member of your society?

Mr. Pigg. No, sir.

Senator Fong. You do not have all hearing aid dealers in your society?

Mr. Pigg. No; we are a society of hearing aid specialists, but we represent a little over——

Senator Fong. You stressed in your statement he must have 2 years of training before he can be certified by your society.

Mr. Pigg. This is the certified member.

Senator Fong. Now, what about the man who is selling hearing aids who is not a certified member, what kind of training does he get?

Mr. Pigg. It is beyond my realm to talk about him.

I will tell you this, if you will, sir, that we have 43 chapters, and in the chapters in the national association, we have members who are certified and members who are not.

Now, the noncertified member, which I think you are directing your question to, still has to abide by our code of ethics. They are under the jurisdiction of our State chapters, affiliated with our national organization. And 38 of these States are licensed, by the way, so in these States they are under the jurisdiction of State laws, which apply also.

If they want to, they can become certified by doing the things that I have touched on here.

Senator FONG. Would you require those not certified to be certified before they could sell a hearing aid?

Mr. PIGG. I think certification is a plateau of competence.

I cannot say I would require it. We are not able to force anybody to do these things. We are a trade organization.

Senator FONG. What you are saying is that your members are qualified to give that service?

Mr. PIGG. We feel this, and I think later on in the testimony that you have read, we point out that we have an agreement with Vocational Rehabilitation, which specifies those people must be certified.

Senator FONG. Thank you.

Mr. PIGG. Shall I continue?

Senator CHURCH. In following through on your prepared statement, in view of the present State laws, I think the committee is pretty well advised on the present status of the law of the various States, and the part you play in that, so rather than go through that, with which we are quite familiar, why don't you insert your statement, to be made a part of the record, and we can move on to questions.

Mr. PIGG. Fine. I appreciate the time you have extended to us.

LICENSING PROGRAM

In addition to our certification program, we have built a licensing program with many consumer protection features which other occupations are late in accepting. Our model bill, however, was not solely the product of the hearing aid industry and we give much credit to the members of cooperating groups—especially the otolaryngologists who assisted in developing it. Our licensing bills protect the consumers as follows:

(1) The hearing aid specialists must show proof of competency.
(2) Prohibited acts are listed.
(3) Penalties for violations are provided.
(4) Each bill provides recourse for the public.
(5) Public members have positions on the boards.

Although our program is young, and relatively few consumer complaints have been entered, State licensing boards have shown by prompt and vigorous action that this system of policing is as effective as that of any profession or business we know of. These bills have been passed in 38 States, even though our program began only 8 years ago. Most, if not all, of the other 12 States are taking steps to become licensed. By comparison you should know that the 14 licensing bills which have been enacted for clinical audiologists have no code of ethics, no recourse for the public, no public members on the board, and award a private organization, the American Speech and Hearing Association, great power over the law.

How well we have succeeded in protecting the consumer as well as the good name of the overwhelming majority of our members may be gaged by the statements of objective observers in a position to judge, but with no ax to grind on behalf of the hearing aid dealer or manufacturer. I will cite only two representative comments, the first from the Florida State Department of Health and Rehabilitative Services:

> It is the consensus of opinion of the division of health, the members of the advisory council to the division of health, and the fitters and sellers of hearing aids in Florida, that the licensure law has gone far in clearing up the misleading advertising and the "fly-by-night" salesmen who sold stock out of the back of their car and then could no longer be found. One of the outstanding benefits has been the upgrading of the business offices and the quality of services rendered to the hard-of-hearing public.

My second quotation is by the distinguished Dr. David M. Lipscomb, director of audiology clinical services, department of audiology and speech pathology at the University of Tennessee. On the progress of hearing aid legislation as enforced by the Tennessee licensing board, Dr. Lipscomb observed as long ago as 1969:

> After nearly 2 years of hearing aid legislation, I am pleased to report a great deal of personal satisfaction with the way in which the stated objectives of the licensing bill are being met. Persons charged with the conduct of business assigned to the board have discharged their duties admirably. Violations of the law have been afforded efficient, equitable, and just treatment. The examination of new license applicants required by the law has been constructed, administered, reconstructed, and recently readministered. The prevailing spirit of ongoing cooperation by all members of the two boards is indeed encouraging.
>
> It appears that the future of the licensing law is bright. From all outward indications, the legislation is achieving its designated objective; i.e., the provision of a set of standards and controls for persons engaged in the measurement of hearing for the purpose of hearing aid sales.

Without really giving the present licensing program a chance, Mr. Nader has produced a model bill, circumventing the wisdom of eminent professionals such as Drs. Cooper and Lipscomb, and the collective legislatures of Florida, Tennessee, and 36 other States. Features of this bill are excellent—they have been modeled after the present laws. Certain other features show a decided preference for clinical audiology. For example, the bill is conspicuous by its enlargement of the definition and function of audiologists, while its definitions for otologists, otolaryngologists, and hearing aid dealers are extremely limited.

The Nader bill flies in the face of all things we have told you today about the extensive training of hearing aid dealers, their continuing updating in the technology of this complex field, and the statements of qualified, disinterested otologists and even audiologists attesting to the competence of hearing aid specialists.

At heart, moreover, Nader's general approach is based on the premise that because a dealer is selling a tangible product at a profit, he is therefore and by definition less ethical than a person who is selling a service pure and simple. And this is the heart of our objection. And if we tend to get emotional in our objections, it is because of the deep insult to us as professionals and as human beings.

Educational Programs

The validity of the educational programs for hearing aid specialists which are an integral part of certification is also under attack. Our society has been one of the most constructive forces in improving the skills of hearing aid specialists. In consultation with reputable educators, we have developed and sponsored many kinds of educational programs, including a comprehensive course in hearing aid technology.

In 1973 our national society has sponsored 21 workshops in every part of the United States with close to 600 hearing aid specialists participating.

Periodically, and in some cases permanently, colleges and universities in every major metropolitan area offer courses in hearing aid technology and service, helping to assure a great reservoir of highly qualified specialists. As far back as 1955, Los Angeles State College began giving courses for hearing aid specialists on audiology and audiometry. These courses were eligible for credit.

Our 43 State chapters conduct periodic seminars and workshops in hearing aid technology. The manufacturers conduct workshops on a continuing basis. Our annual convention stresses education. We have also published many educational materials featuring current research, technology, and methods.

These many educational offerings have recently been reviewed, and we have made concrete plans to expand them. This will include the employment of a full-time director of education, who will incorporate hearing aid audiology programs in accredited institutions of higher learning. We believe that all we have done in education, and all that we plan to do, materially benefits the consumers by providing them with continually improved skills and services.

We find that further sophistication is becoming possible. Since there are certain hearing problems which demand medical attention, the otologists have developed for us a list of those conditions which a hearing aid specialist must recognize and then recommend that his client be examined by a physician. These conditions fall within the scope of the hearing aid specialists' nonmedical proficiency, and can be recognized through interview and observation. After consultation with the Intersociety Committee on Hearing, a committee which has representation from the five major hearing health organizations, we have incorporated a list of these conditions in our model bill. This is in accordance with our own policy of full cooperation with other groups, and our determination to upgrade the field as experience and needs dictate.

A few critics of our practices have argued that a medical examination should be required in all cases before a hearing aid can be fitted. Some have proposed that an examination by a clinical audiologist be mandatory as well. We have the support of otology in not demanding it by law. We feel that it is neither feasible nor constitutional, since, among other things, it may infringe the religious or personal convictions of some of our citizens, and would restrict the freedom of choice of all of our citizens. It becomes still another deterrent discouraging the hearing impaired from seeking the help they need. In addition, as we said, most cases do not require medical intervention.

Consumer Programs

We have engaged in a number of consumer interest programs, in addition to licensing and certification. I do not have time to describe them in detail but I think some mention of them will demonstrate how much we have been able to accomplish with fairly limited resources. For example, we have a cooperative agreement with the Rehabilitation Services Administration of HEW. Let me read to you from a letter from Boyce Williams, director of the Office of Deafness and Communicative Disorders:

> The agreement made between the National Hearing Aid Society and the Rehabilitation Services Administration has done much to make it possible to reach more hearing impaired people in need of services. This is reflected in the annual increase in numbers of hard of hearing persons referred to the State vocational rehabilitation agencies by hearing aid dealers for the many services, including provision of needed hearing aids, that are available to them through vocational rehabilitation.
>
> Hearing aid dealers are a recognized and valued arm of the vocational rehabilitation team. As the relationship between hearing aid dealers and the State vocational rehabilitation agencies deepens and becomes better understood, we believe that the benefits presupposed by the agreement for all parties will gain considerable ground.

We maintain a public information program designed primarily to remove the mystery from hearing aids and to encourage the hearing impaired to seek appropriate help.

We have set up a program—called a hearing aid bank—to supply hearing aids to indigent children unable to secure financial aid from existing public or private sources.

We have notified Government agencies, our consumer organizations, and the news media that we can and will stand by our commitment to consumers. We have asked them to forward any complaints or inquiries about hearing aids to us for investigation and resolution. These groups include the American Association of Retired Persons, Mrs. Virginia Knauer's Office of Consumer Affairs, the National Better Business Bureaus, over 2,000 newspapers, and the State licensing boards.

We cooperate with the manufacturers in their hearing aid helpline. This is a toll-free number and has been publicized to clinics, audiologists, otologists, and otolaryngologists, asking them to forward to us any complaints or inquiries.

Yet, despite all these consumer protection mechanisms, we actually receive very few complaints.

Facts and Truth

Mr. Chairman, we need to focus more attention on the public education aspects of our programs, since consumer abuses do not appear to be the burning issue which others pretend. Too frequently, the alleged abuses are a fabrication by those who are working toward annihilating the present hearing aid delivery system, as we have proven in instances across the country. This becomes clearly evident when we find that instead of taking these alleged abuses to the law enforcement and licensing agencies, or the consumer affairs authorities, for proper investigation, and real help to the consumers, our critics file charges

against us in the public press and attempt to convict us without a hearing.

We have nothing to fear from the truth, but one of our big problems is to make the truth known, and that is our purpose in being present today. We have a considerable body of objective evidence that the consumers are indeed well served by the hearing aid industry. In 1971, Market Facts, Inc., a prominent research firm which has conducted studies for a number of Government agencies and private corporations, made a study to test levels of consumer satisfaction. This showed that a solid 90 percent of hearing aid wearers are satisfied with the service they received from the industry. Services surveyed included those provided by hearing aid specialists at the time the clients had their hearing tested by the dealer, at the time of purchase, and in the after-purchase period. Less than 2 percent rated themselves as "very dissatisfied." This is a record which is seldom matched in any other field of human endeavor. And, you may be interested in knowing that it verifies conclusions reached by a U.S. Public Health Service survey made 6 years earlier that showed at least 90 percent satisfaction level among hearing aid wearers, which was reported to your committee in our testimony at the 1968 hearings.

Cost Factors

Among the so-called consumer abuses, which are so frequently exaggerated, an especially misleading one concerns the price of hearing aids. To provide their point, our critics recite the differences between manufactured cost and retail price to the client, and then wring their hands in dismay, and call the hearing aid specialists "profit-mongers." If this were pure profit, it would indeed be cause for alarm, but, Mr. Chairman, their economic facts are as wrong as many of the other things they say. They are confusing markup with profit—a serious mistake which may prove fatal to the good care we want for the hearing impaired—and I am sure you perceive the fallacy immediately.

I have in my hand a discussion paper developed by the American Speech and Hearing Association in 1970. It delineates in great detail all the many functions and services involved in evaluating hearing loss and the fitting and servicing of hearing aid clients. It puts a relative cost factor on each of these services, on the basis of so many points or fractions of points for each service. I have marked with my pen 26 services routinely performed by hearing aid specialists, and usually included in the purchase price of a hearing aid. If the audiologists go full-scale into the retail hearing aid business, as some of them propose to do, the hearing aid client will have to pay for each of these services listed by the audiologists. So when someone claims he can sell a hearing aid for $100, he'd better mention too that he will tack on additional charges that can easily run more than $200 extra.

These services, now covered by the hearing aid specialist, include the costs of equipping, staffing, and operating an office, the costs of employment and training personnel and their continuing salaries, the costs of making hearing aid evaluations to determine whether amplification will help, the costs of licensing fees, the costs of taxes—local, State, and Federal property and income taxes—advertising, the costs of continuing education, the costs of fitting and adapting the instru-

ment to conform to individual needs, the time the hearing aid specialist spends to carefully and repeatedly instruct the client in the care and use of the instrument, and the time the hearing aid specialists must use to provide continuing moral support and reinforcement to reassure the client and assist him in becoming a successful hearing aid wearer.

Some Make Easy Adjustment

Please do not underestimate the value of this counseling. Our experience has proven that this followup helps to make the critical difference between the person who abandons the idea of hearing aid use and throws it in the dresser drawer as opposed to those who make a satisfactory adjustment, and receive its benefits. Some clients make a relatively easy adjustment, but for others it is very difficult. The time a hearing aid specialist spends with a client depends upon individual need, but the costs of the time spent must be amortized over an entire clientele. This system, which includes all these services and more in the original purchase price of a hearing aid, gives maximum encouragement to the client to avail himself of the dealer's skills, whereas separate fees for each service would deter the handicapped person.

I might add that many of our members will also make house calls to serve the incapacitated or the homebound. We are being encouraged to do so by the National Council on the Aging, who recommend to their participating organizations that the elderly be provided with those services which will help them remain within their own environment and in their own homes. This recommendation was an outgrowth of the 1971 White House Conference on Aging. HEW Secretary Caspar Weinberger has reemphasized this in his statement published in the Federal Register on September 4, 1973.

The profit margin, as opposed to markup, therefore is reasonable. This is substantiated by a study made by the auditor general of the State of Michigan, in an analysis of hearing aid dealer sales and expenses for the 1971 calendar year. This disclosed that without including commissions, the average selling and administrative expense amounts to $97.41 per hearing aid, and, Mr. Chairman, this does not include the wholesale cost of the instrument. We are submitting the full text of the Michigan Hearing Aid Dealer Cost Study for the record.* A Massachusetts study showed that the median net annual income for Massachusetts hearing aid specialists is $11,500. Hardly exorbitant. Nationally, the typical hearing aid dealer earns approximately $15,000 a year, according to a 1970 survey by The Hearing Dealer, a trade publication.

While the cost of hearing aids under the present delivery system is frequently the object of criticism, the matter is placed in perspective when we compare this cost with the costs of dispensing hearing aids through clinics. Although very little information has been made available to the public regarding the true costs of dispensing hearing aids from public funds, a couple of examples which we do have may offer enlightenment. A report about a clinic in Montana showed that on a grant of $36,150, they were able to dispense only 40 hearing aids,

*See appendix 2, item 12, p. 139.

making the average cost $900 each. And this cost does not include the costs of equipping the clinic, which was paid by the State. A report from Kentucky offers similar evidence of the high cost of dispensing hearing aids through clinics. No reliable figures are available to show the costs of dispensing hearing aids through the Veterans' Administration, but estimates range as high as $800 per hearing aid and additionally the system creates considerable disruption and inconvenience for the recipients.

Private System is More Efficient

If these reports are typical, and we have no reason to believe that they are not, the taxpaying public should be shocked at this wanton expenditure of their money, when the private delivery system is able to handle the job far more efficiently and economically.

I would like to conclude with another quotation from the otologist, Dr. Aram Glorig, whom I cited earlier. It's a reminder of the challenge:

> The large numbers of the individuals who need otoaudiological care demands that a comprehensive delivery system be used. It demands the expertise of the physician, the audiologist, and the hearing aid specialist. The task is much too difficult to be handled competently otherwise. . . .
>
> Each member of the team must acknowledge each member's qualifications and work to maintain a most efficient delivery system. The task is too large and demands too much of all of us to waste time and energy bickering and empire building. Such time would be better spent increasing our knowledge and pooling our efforts toward bettering the status of the impaired hearing individual.

Thank you, Mr. Chairman, for the time and courtesy which you and your colleagues and staff members have given us today. My associates and I will be happy to try to answer any additional questions which you may have.

Senator Church. Thank you very much.

On the matter of service—you have given that quite a lot of emphasis—you have said that this package the dealer gives is preferable to any breakdown in the prices, on the price of the charge of the hearing aid itself, and the prices for services that would be rendered. I am in some doubt in my own mind as to what happens in special cases.

Suppose, for example, a person who has already purchased a hearing aid comes back for another model; is he charged less because the dealer is already familiar with his needs, or does he pay the same as everyone else?

Mr. Pigg. I think in my testimony, Senator, that I mentioned the fact that the cost is amortized over the whole system. Some people need care every week or two, if they have never worn a hearing aid before, while others need little followup service.

It is something like auto insurance. My insurance costs just as much as for the fellow who wrecks a car every 6 months, if I could use this as a very bad example, in amortizing the cost over the entire picture. You will notice, after all of this is done, that no dealer is getting very rich on the situation.

Senator Church. But the answer to my question is that even though the dealer in this particular case might be fully familiar with having fitted their customer before, he does not get any special discount on that account by virtue of, if he were to need, and were to come in to buy a new device?

TRADE-IN ACTUALLY IS DISCOUNT

Mr. PIGG. I will let you in on a little trade secret if I may.

We are very happy with the people who place their confidence in us, and when they come back to us, we may give what is called a tradein, and this is not like the used car business.

It actually amounts to a discount. Hearing aid specialists may be able to salvage the aid as a loaner; that is about the extent of it, so a second hearing aid may be cheaper.

Senator CHURCH. Is that a general practice among the dealers you represent through your association?

Mr. PIGG. I cannot quote policy, but most of them I have talked to have this in mind.

I would rather not be quoted as setting a policy for all of them. Generally speaking, yes, it is true.

Senator CHURCH. Supposing a new customer has a prescription for a specific model, is he charged less because he needs less dealer attention?

Mr. PIGG. I would have to turn this over to people who are familiar with audiological referrals.

In our part of the country, the population is very sparse, as it is in yours, and the nearest clinical audiologists are in Denver, so I will let Mr. Rich answer that question.

Mr. RICH. I think, again, policies vary in that there are some instances where there is allowance made for this, and others where there is not.

I think that one of the reasons for this is the area of assuming responsibility. The prescription, that word that has been thrown around so often, does not really exist.

You cannot, with hearing aids, do either the prescribing and the producing in mathematically accurate terms as you can with glasses.

The hearing aids can be described, or some criteria can be stated; then whoever assumes responsibility almost has to cover the financial matters as well.

When the prescriber assumes responsibility, perhaps a division of finances is appropriate.

I would like to comment on your question. I think the package deal, so often mentioned, with all of the services included, is a subject which is really evolutionary.

Past experience has proved that people have been happier, or accepted it more readily. They would have been discouraged about coming back for services, should they always have to dish out a 10 or 5 dollar bill.

A "fee for services" has been tried at places on occasion. I think in the future, however, such a possibility may develop through public education for hearing aid wearers, so I do not think this is fixed forever.

Senator CHURCH. Is a warranty on the hearing aid one of the services the dealer provides?

Mr. RICH. Is the warranty?

Senator CHURCH. Yes.

Mr. RICH. The dealer usually is the one who fulfills the warranty, or is the intermediary in fulfilling the warranty.

Senator CHURCH. The warranty, I take, is a manufacturer warranty?

Mr. RICH. Usually by the manufacturer; yes, as a rule.

Senator CHURCH. Does the manufacturer assume the cost of replacement in the case of a defect, or is that cost assumed by the dealer?

Mr. RICH. It is assumed by the manufacturer within the terms of the contract.

Senator CHURCH. Now, you have made some recommendations concerning Medicare, and those recommendations will be placed in full in the record.*

HIGH COST FIGURES THROUGH CLINICS

Also, you have given us some figures, very high cost figures, with respect to the furnishing of hearing aids through clinics.

Earlier today we had testimony that in New York State under the New York State Medicaid program, the cost was $225. That was the ceiling, and that the program is working very well. What comment would you have to make on that? It seems to be a very large program, and the testimony we had today was it was operating very satisfactorily.

Mr. PIGG. Our executive secretary said that this cost does not include the otological and audiological workups for one thing, so you have to add that onto that cost. If you would be interested, Senator, in how this same type of plan is working in California, my vice president, Ms. Daniel, would be very happy to explain it to you.

Is that all right with you?

Senator CHURCH. Very well.

Ms. DANIEL. As you know, in California we are under title XIX, and it is called Medi-Cal.

You have in your portfolio from us a complete explanation of the manner in which we would like to make our presentation for Medicare,* the same as we are using in California, that during some 5 or 6 years has proved efficient.

Now, on the cost that you referred to, that New York is projecting or has projected, our cost in California under the Medi-Cal plan is the factory cost of the aid plus a specific markup that we are allowed.

At this time, Senator Church, it is being reviewed, and we are assured that we are going to be paid an additional amount of money.

It has not been increased in these past 5 or 6 years.

It is something that I personally would hate to be running my office on, only, and not have the additional care of others. But it has worked. Rehabilitation uses the same formula. Crippled children services uses the same formula, and it is all within the price structure of about $200 to $250.

CALIFORNIA MEDI-CAL FORMULA

I do not think I have any aids going over that, and when my billing is made, in our formula in California, we bill separately for the ear mold, along with the hearing aid, and this is included in this price. I

*See appendix 2, item 11, p. 138; see also appendix 3, p. 168.

am quoting you, as are the batteries, and our services. The State of California under this program requires six post-fitting visits.

We must document these things, and have them available for our Medi-Cal investigators to check on for our health care services people.

If I may refer back to something that came up before, all of our Medi-Cal people have a clearance from an otolaryngologist or a physician if the otolaryngologist is not available in their community. In California, under Medi-Cal, this is true.

Senator CHURCH. You mean an examination and reference by the physician?

Ms. DANIEL. The client, the recipient may go to the person of their choice, but the doctor does the medical examination. There is a fee for that, that he bills to Medi-Cal, and then there is a fee from the doctor's office that is billed to Medi-Cal for the audiogram, including our SRT, our MCL, our TD scores. Then it comes back to us.

As a rule, most of us like to recheck as we work, but the doctor has to be the one that authorizes the hearing aid.

Ninety percent of the time it is the otolaryngologist. Now, if the doctor feels and wishes that this recipient of the Medi-Cal program should have it, he will send them to the audiologist, and here again there will be further diagnostic work and a hearing aid recommendation if you wish to call it that. Then they will be referred to the hearing aid dealer of their choice. This is in the law, that they go where they wish to go.

Senator CHURCH. And this would be the pattern you suggest?

Ms. DANIEL. Yes. This is what we are presenting to you as a workable program, financially stable, well done, as our California plan has been.

Senator CHURCH. Fine. Thank you very much.

I think I have no further questions.

It is 6:10, and it is time to close the hearing for today.

We will resume at 2 o'clock tomorrow afternoon.

Thank you very much.

[Whereupon, the hearing was recessed at 6:10 p.m.]

APPENDIXES

Appendix 1

MATERIAL FROM RETIRED PROFESSIONAL ACTION GROUP AND RELATED COMMENTARY

ITEM 1. PROPOSED MODEL STATE LAW REGULATING THE FITTING AND SELLING OF HEARING AIDS, SUBMITTED BY RETIRED PROFESSIONAL ACTION GROUP, AUGUST 20, 1973*

PUBLIC HEALTH CODE

ACT NO. ———

REGISTRATION AND REGULATION OF HEARING AID DEALERS

Sec.

1. Short Title
2. Declaration of Policy
3. Definitions
4. Powers and Duties of the Department
5. Advisory Council Established; Powers and Duties
6. Oath of Members of Council
7. Certificate of Registration or Trainee Temporary Certificate of Registration Required
8. Act Does Not Apply to Certain Persons and Organizations
9. Qualifications of Applicants for Registration
10. Trainee Apprenticeship Course
11. Examination and Registration Fees
12. Disposition of Fees
13. The Examination
14. Certificate of Registration
15. Grounds for Suspension, Revocation, or Refusal to Issue or Renew Certificates of Registration or Trainee Temporary Certificates of Registration
16. Unethical Conduct Defined
17. Trial Period; Receipt to be Furnished to Purchasers Of Hearing Aids
18. Minimal Procedures and Equipment
19. Renewal of Certificates of Registration or Trainee Temporary Certificates of Registration
20. Procedure for Handling Complaints and Denials, Revocation, or Suspension of Certificates of Registration or Trainee Temporary Certificates of Registration, Public Hearings
21. Attorney General and County Prosecuting Attorneys
22. Penalties
23. Power of Injunction
24. Establishment of Academic Courses in the Fitting, Selling and Servicing of Hearing Aids
25. Effective Date

SECTION 1. SHORT TITLE

This Act may be cited as "The Hearing Aid Dealers Act".

SECTION 2. DECLARATION OF POLICY

The fitting and selling of hearing aids is hereby declared to affect the public health and welfare, and is subject to regulation in the public interest. For protection of the public, this Act requires registration of any person engaged in the fitting and selling of hearing aids. It is intended to establish higher qualifications for such persons, to provide for penalties against unethical or improper conduct by such persons and to provide educational opportunities for persons desiring to become hearing aid dealers in order to serve the hearing impaired.

* For additional discussion, see testimony by Mr. Frank Dickey, pp. 11–14, and p. 19.

SECTION 3. DEFINITIONS

For the purposes of this Act:

(1) "Department" means the Department of Health, which is charged with responsibility for administration of this Act; and, as the context requires, the term means the chief officer of that Department and the duly authorized delegates of the chief officer.

(2) "Council" means the Advisory Council to the Department of Health.

(3) "Otolaryngologist" means a physician licensed in the State who specializes in ear, nose, and throat, and is a diplomate or eligible for qualification by the American Board of Otolaryngology as an otolaryngologist.

(4) "Otologist" means a physician licensed in this State who specializes in the ear, and is a diplomate or eligible for qualification by the American Board of Otolaryngology as an otolaryngologist.

(5) "Audiologist" means an individual who is eligible for the American Speech and Hearing Association certificate of clinical competence in audiology who practices audiology, which means the application of principles, methods, and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to hearing and disorders of hearing for the purpose of evaluating, identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals and/or groups of individuals. For the purposes of this subsection the words "habilitation" and "rehabilitation" include, but are not limited to, hearing aid evaluation and recommendation, auditory training, and speech reading.

(6) "Hearing Aid Dealer" or "registrant" means a person who has been issued a Certificate of Registration by the Department, which authorizes such person to engage in the business of fitting and selling hearing aids.

(7) "Fitting" includes the physical acts of adjusting the hearing aid to the individual, taking audiograms, and making ear molds, advising the individual with respect to hearing aids, audiogram interpretation, and assisting in the selection of a suitable hearing aid for the sole purpose of the sale of a hearing aid.

(8) "Sale" or "selling" shall include any transfer of title to a hearing aid or transfer of the right to possession of a hearing aid by lease, bailment, loan, or any other contract, together with pricing, delivery, and guaranteeing of the hearing aid. Wholesale transactions and gifts by public or charitable organisations are not included.

(9) "Hearing Aid" means any electronic instrument or device worn on the human body represented as aiding or compensating for impaired human hearing, together with any parts, attachments or accessories of such instrument or device, except batteries and cords.

(10) "Trainee Temporary Certificate of Registration" means the certificate which is issued by the Department to a qualified person, authorizing such person to engage in the training program prescribed by this Act; and to perform, under the supervision of a registrant, acts involved in the fitting and selling of hearing aids.

(11) "Trainee" means a person who does not qualify as a registrant, but who undertakes to do so through successful completion, under the direct and personal supervision and instruction of a registrant, of the training program prescribed in this Act.

SECTION 4. POWERS AND DUTIES OF THE DEPARTMENT

The powers and duties of the Department under this Act are as follows:

(1) To establish an administrative subdivision within the Department to assist in carrying out the provisions of this Act.

(2) To employ and fix the compensation of persons needed to assist the Department in carrying out the provisions of this Act.

(3) To authorize all disbursements necessary to carry out the provisions of this Act and to receive and account for all fees.

(4) To approve examinations of applicants for certificates of registration. The examination shall be prepared by an Examining Committee with the advice of the Department and the Council. The Examining Committee shall consist of an otologist or otolaryngologist, an audiologist, and a hearing aid dealer who holds a certificate of registration under this Act. The three persons need not be members of the Council. If they are not members of the Council they shall be appointed for the purpose of carrying out this provision.

(5) To administer and to grade, with the assistance of the Examining Committee, qualifying written and oral and practical examinations to test the knowledge and proficiency of applicants for certificates of registration.

(6) To designate the time and place for examining applicants for certificates of registration.

(7) To establish annual minimum requirements of continuing hearing aid education for renewal of certificates.

(8) To promulgate, with the advice of the Council, rules and regulations consistent with the laws of this State, which are deemed necessary to carry out the provisions of this Act, and to publish and enforce such rules and regulations.

(9) To purchase and maintain, rent or acquire, audiometric equipment and facilities necessary to carry out the examination of applicants.

(10) To conduct investigations into the business and ethical background of any person who makes application for a certificate of registration or a trainee temporary certificate of registration, in order to determine the applicant's qualifications.

(11) To issue and renew certificates of registration and trainee temporary certificates of registration.

(12) To investigate alleged irregularities and complaints related to the fitting and selling of hearing aids and to conduct such public hearings regarding any irregularities and complaints as are deemed necessary by the Department with the advice of the Council.

(13) To suspend or revoke certificates of registration and temporary trainee certificates of registration with the advice of the Council.

(14) To require the periodic inspection and calibration of audiometric testing equipment of each registrant, and to carry out the periodic inspection of facilities of persons who sell hearing aids to determine that minimal procedures and equipment are used.

(15) To delegate such ministerial duties to the Council as the Department shall deem proper.

(16) To record Council proceedings, and to maintain a register of persons whose certificates have been suspended or revoked. The books and records concerning the Council proceedings shall be prima facie evidence of all matters reported therein.

(17) To make available for public inspection all the Department's records pertaining to this Act.

(18) To furnish, upon the oral or written request of any person, a list of persons registered under the provisions of this Act.

SECTION 5. ADVISORY COUNCIL ESTABLISHED; POWERS AND DUTIES

(1) There is hereby created an Advisory Council to the Department regarding Hearing Aid Dealers consisting of nine members who shall be residents of this State. Five members shall constitute a quorum. Two members shall be hearing aid dealers with at least three years of experience in fitting and selling hearing aids at the time of appointment, and except for those initially appointed under this Act shall hold valid certificates of registration issued under this Act. One member shall be an audiologist with at least three years of experience in audiological practice at the time of appointment. One member shall be an otolaryngologist or otologist. One member shall be a physician engaged in general practice. One member shall be a consumer hearing aid user. One member shall be a representative of a government or non-government consumer protection agency. One member shall be a representative of the State Educational Agency. One member shall be the chief officer of the Department or his delegate. The members of the Council shall be appointed by the Department, and the first appointments shall be made within sixty days after the effective date of this Act. In making such appointments, the Department shall consider nominations made by any State or voluntary agency or private citizen. The terms of office of members of the Council shall be three years. Any vacancy on the Council shall be filled for the remainder of the unexpired term and with a person having the same qualifications as the former Council member.

(2) Members of the Council shall receive no compensation, but each shall be entitled to reimbursement for actual expenses incurred in the performance of duties under this Act, payable from the fund established by Section 12 of this Act.

(3) The Council shall:

(a) Meet within thirty days after appointments are complete and elect a chairman and a vice-chairman from its own members. Each such officer shall hold office for one year.

(b) Hold a meeting twice each year and hold other meetings at such times and places as the Department chairman, or a quorum of the Council's members may direct.

(c) Recommend to the Department: (1) examination procedures for applicants, (2) minimum requirements for the testing of equipment, (3) minimal procedures necessary in fitting and selling of hearing aids, (4) public hearings in accordance with subsection 4 (12), (5) a code of ethics to assure improvement of services and procedures to be followed by registrants, and (6) specialized educational courses for persons wishing to become hearing aid dealers. The Council shall be guided by the Trade Practice Rules for the Hearing Aid Industry promulgated by the Federal Trade Commission July 20, 1965, or as amended.

(d) Make a report each year to the Department and to the Governor of all its official acts during the preceding year.

(e) Hear the charges, defenses, and evidence in hearings conducted for alleged violations of any of the provisions of this Act or any of the regulations issued pursuant to this Act.

SECTION 6. OATH OF MEMBERS OF COUNCIL

Immediately upon appointment and before entering upon the duties of office, each member of the Council shall take the constitutional oath of office, and shall file it with the Department of State, which shall issue to the member a certificate of appointment.

SECTION 7. CERTIFICATE OF REGISTRATION OR TRAINEE CERTIFICATE OF REGISTRATION REQUIRED

—— days after the effective date of this Act, it shall be unlawful for any person in this State to engage in the business of fitting and selling hearing aids, or in any way advertise or represent that he practices the fitting and selling of hearing aids, unless such person holds a certificate of registration or a trainee temporary certificate of registration issued by the Department.

SECTION 8. ACT DOES NOT APPLY TO CERTAIN PERSONS AND ORGANIZATIONS

(1) Nothing in this Act shall prohibit a corporation, partnership, trust, association, or other like organization from engaging in the business of fitting and selling hearing aids without a certificate of registration, if all fitting and selling of hearing aids is conducted by registrants. Such organizations shall file annually with the Department a list of hearing aid dealers directly or indirectly employed by it. Such organization also shall file with the Department a statement on a form approved by the Department that it submits itself to the rules and regulations of the Department, and the provisions of this Act which the Department shall deem applicable to such organization. Such organization engaging in the business of fitting and selling hearing aids at retail shall maintain a place of business in this State, which is an actual, established physical location from which the organization conducts its business and where applicable books and records are maintained.

(2) This Act does not apply to a person engaged in the practice of fitting and recommending hearing aids, if such practice is part of the academic curriculum of an accredited institution of higher education, or part of a program conducted by a charitable institution or non-profit organization which is supported primarily by voluntary contributions, or part of a program of a governmental agency, provided that the organization does not sell hearing aids.

(3) This Act does not apply to any physician licensed to practice medicine in this State who does not sell hearing aids.

(4) This Act does not apply to any audiologist practicing audiology in this State who does not sell hearing aids.

(5) This Act does not apply to any person who sells hearing aids only upon the prescription or recommendation of a medical ear specialist or an audiologist if such person does not engage in testing or fitting for the purpose of selling a hearing aid.

SECTION 9. QUALIFICATIONS OF APPLICANTS FOR REGISTRATION

(1) Any person engaged in the fitting and selling of hearing aids from an established place of business at a permanent address in this State for a period of not less than two years prior to the effective date of this Act shall upon sworn application to the Department be entitled to a certificate of registration. Every such registrant shall be required to take the first qualifying examination given by the Department provided that the first examination of a registrant who is a member of the Council

or Examining Committee may be delayed not longer than the third examination given by the Department so that arrangements can and shall be made under which no such member will participate in the preparation, administration, or grading of an examination taken by that member.

(2) If any person who received a certificate of registration by experience fails to take or pass the first examination required by this section the certificate of registration of such person will be automatically revoked; and the Department shall advise such person that he may apply for a trainee temporary certificate and undertake further training under Stage III of the Training Apprenticeship Course prescribed by this Act in Section 10. If this situation occurs the trainee must work under the supervision of a sponsor registrant.

(3) Each applicant for a certificate of registration or a trainee temporary certificate of registration shall be at least 18 years of age and not under disability of minority; shall be of good moral character; shall have the educational equivalent of successful completion of a four year course in an accredited high school and shall have an established business address in this State. Each such applicant shall submit to the Department a sworn application on a form approved by the Department, accompanied by the prescribed fee.

(4) Any person who holds a currently effective certificate of registration or license to fit or sell hearing aids in another State and is qualified under paragraph (3) of this section may make sworn application to the Department to take the qualifying examination without any trainee period. Upon passing such examination, such person shall receive a certificate of registration. If such person fails to pass the examination, the procedure shall be as provided in paragraph (2) of this section.

(5) Any person who meets the requirements of paragraph (3) of this section and who desires to become a registrant by successfully completing the training program outlined in Section 10 of this Act may submit a sworn application to the Department, for a trainee temporary certificate of registration. Previous experience shall not be required for a trainee certificate. Upon receipt of such certificate, the trainee becomes subject to all of the provisions of this Act and regulations issued under it, and shall under the supervision and instruction of a registrant undertake the training program described in Section 10 of this Act. The application shall be accompanied by a sworn statement from the registrant who will be the applicant's supervising sponsor that the sponsor accepts responsibility for all acts of the applicant relating to fitting and selling of hearing aids during the training period, and that during at least stages I and II of the training program the applicant will receive training and supervision in the same office occupied by the registrant.

Section 10. Trainee Apprenticeship Course

(1) Stage I.—The trainee must work for three months under the direct and personal supervision of, and in the same office as, the sponsor registrant. During this stage, the trainee is not allowed to do any testing, fitting, or selling.

(2) Stage II.—This training stage lasts for six months, during which the trainee may do testing for the proper selection and fitting of hearing aids and make ear impressions. During this period the trainee must work under the direct and personal supervision of, and in the same office as, the sponsor registrant. During this stage, the trainee may not make final testing or final fitting.

(3) Stage III.—This training stage lasts for three months or until the time the next examination thereafter is given, whichever is longer. During this time the trainee may engage in all of the activities of a registrant, but must work under the supervision of the sponsor registrant.

(4) The three stages described above must be completed with no time lapse between stages except as authorized by the Department for justifiable cause shown by the trainee or sponsor or both. A trainee who desires to change sponsors shall furnish the Department with a sworn request, giving reasons for the request, accompanied by a sworn statement from the new sponsor with the undertakings required by subsection 9(5) of this Act, and accompanied by the trainee's temporary certificate of registration. If the transfer is approved, the certificate will be revalidated without charge. If a sponsor desires to terminate responsibilities undertaken with regard to a trainee, he shall give the trainee 10 days written notice, giving reasons, and notify the Department accordingly by registered or certified mail.

(5) Upon completion of the three stages described in this section, the trainee shall take the qualifying examination given by the Department; and upon passing that examination, shall receive a certificate of registration.

(6) If a trainee who holds a trainee temporary certificate of registration takes and fails to pass the qualifying examination, he must work under the provisions of Stage III of the trainee apprenticeship period until the next examination.

(7) No trainee shall perform any hearing health services for a customer without the customer being informed that such services are being performed by a trainee rather than by a registrant. Such notice shall be given verbally by the trainee or by the registrant sponsor, and a trainee identification badge must be worn disclosing the status of the trainee. In each case, records shall be kept showing the particular services performed by the trainee.

(8) At such time as a course in fitting and selling of hearing aids, approved by the Department and the Council, shall be established in this State as provided in Section 24, satisfactory completion of such course shall qualify the student to take the examination required by this Act without complying with the requirements of the trainee apprenticeship course provided in this section.

Section 11. Examination and Registration Fees

(1) Every initial application for a certificate or temporary certificate of registration shall be accompanied by a fee of $——— to cover costs of investigation and verification. No part of this fee shall be refunded.

(2) The annual certificate of registration fee shall be $———.

(3) The annual trainee temporary certificate of registration fee shall be $———.

(4) The annual renewal fee for every certificate or temporary certificate of registration shall be $———.

(5) The fee for each examination shall be $———.

(6) The delinquency fee on renewals shall be $———.

If any certificate or temporary certificate of registration is issued after January 1, in any year the annual fee shall be reduced in such equitable manner as may be provided by regulations promulgated by the Department.

Section 12. Disposition of Fees

All fees collected under the provisions of this Act shall be paid to the Department. The Department shall deposit said funds with the State Treasurer, to the credit of the Hearing Aids and Devices Trust Fund, which is hereby established. The costs of administration of this Act shall be paid from the moneys collected under this Act.

Section 13. The Examination

(1) An applicant must make a grade of 70 percent or more in each area, subject or technique specified in this Section to qualify for a certificate of registration. The oral, written and practical examination shall be prescribed by the Department in accordance with Section 4(4) and shall be given at least twice a year, or as often as necessary to process applications received. A person wishing to take the examination shall notify the Department of such intention and the Department shall supply such person with an application on a form prescribed by the Department. The applicant shall execute the application and send it to the Department together with the examination fee. If the Department finds that the applicant is eligible to take the examination, it shall notify the applicant in advance of the time and place for the examination. If the application is rejected, the examination fee shall be refunded. If the application is approved and the applicant does not take the examination, the fee shall not be refunded, unless the Department finds that there are justifiable reasons for the applicant's failure to take the examination, in which case it shall be applied to the fee for a future examination. No person will be permitted to take the examination more than three times.

(2) All applicants taking the examination at the same time shall be given the same written, oral and practical examination. The examination must be such that, in order to pass, the applicant must establish knowledge and proficiency in each of the following areas, subjects and techniques:

(a) Tests of knowledge in the following areas as they pertain to the fitting of hearing aids:

(1) Basic physics of sound.

(2) The human hearing mechanism, including the science of hearing and the causes and rehabilitation of abnormal hearing disorders.

(3) Structure and functions of hearing aids.

(4) Basic psychology relating to the hearing impaired.

(5) Availability of social service resources and other special resources for the hearing impaired.

(6) Knowledge of the provisions of this Act, with emphasis on criminal provisions and the grounds on which a certificate of registration may be suspended or revoked.

(b) Tests of proficiency in the following techniques as they pertain to the fitting of hearing aids:

(1) Pure tone audiometry, including air conduction testing and bone conduction testing.

(2) Recorded speech audiometry, including speech reception threshold testing and speech discrimination testing.

(3) Theory and practice of masking methodology.

(4) Recording and evaluation of audiograms and speech audiometry to determine hearing aid candidacy.

(5) Selection and adaptation of hearing aids and testing of hearing aids.

(6) Basic repair and maintenance of hearing aids.

(7) Taking earmold impressions.

(8) Other skills as may be required for the fitting of hearing aids.

(c) The examination shall be revised annually by the Examining Committee so that it includes current and significant information which pertains to the categories in this Section. No examination of any established association of hearing aid dealers or manufacturers shall be used exclusively to replace this examination.

SECTION 14. CERTIFICATE OF REGISTRATION

Upon passing the examination the Department shall issue to the applicant a certificate of registration, under the seal of the Department. The certificate of registration shall be prominently displayed at all times in the registrant's place of business.

SECTION 15. GROUNDS FOR SUSPENSION, REVOCATION, OR REFUSAL TO ISSUE OR RENEW CERTIFICATES OF REGISTRATION OR TRAINEE TEMPORARY CERTIFICATE OF REGISTRATION

The Department may suspend, revoke or refuse to issue or to renew any certificate issued under this Act, for any of the following reasons:

(1) Conviction of a felony or misdemeanor involving moral turpitude.

(2) Willfully making a false statement to the Department in an application for a certificate or for the renewal or any certificate or with respect to any matter within the scope of the Department's powers and duties under this Act.

(3) Altering any certificate with fraudulent intent.

(4) For unethical conduct as defined in section 16, or for gross malpractice in the fitting or selling or hearing aids.

(5) Violation of any of the provisions of this Act, or of any of the provisions of any rules or regulations promulgated pursuant to this Act.

(6) Selling a hearing aid to any person unless within the preceding three months the person has been examined by an otolaryngologist or an otologist, and a written recommendation for a hearing aid has been made by such physician *or* by an audiologist eligible for certification by the American Speech and Hearing Association to whom the person has been referred by such physician. This does not apply to replacement of an identical hearing aid within one year of its purchase.

(7) Departing from the medical or audiological recommendations obtained pursuant to subsection (6) without consultation and written approval from the physician or the audiologist involved.

SECTION 16. UNETHICAL CONDUCT DEFINED

Unethical conduct shall include:

(1) The obtaining of any fee or the making or attempting to make any sale of any hearing aid by fraud or misrepresentation.

(2) Employing directly or indirectly any suspended or unregistered person to perform any work requiring a certificate of registration or a temporary certificate of registration.

(3) Using or causing or promoting the use of any advertising matter, promotional literature, testimonial, guarantee, warranty, label, brand, insignia, or any other representation, however disseminated or published, which is misleading, deceitful, or untruthful.

(4) Advertising a particular model, type, or kind of hearing aid when the offer is not a bonafide effort to sell the product so offered as advertised and at the advertised price. Among actions or procedures which will be considered in determining whether such advertisement has been made are the following:

(a) The creation, through the initial offer or advertisement, of a false impression of the product in any material respect.

(b) The refusal to show, demonstrate or sell the product offered in accordance with the terms of the offer.

(c) The disparagement, by actions or words, of the product offered or the disparagement of the guarantee, credit terms, availability of service, repairs, or parts, or in any other respect in connection with it.

(d) The showing, demonstrating, and in the event of sale, the delivery of a product which is unusable or impractical for the purpose represented or implied in the offer.

(e) The refusal, in the event of sale of the product offered, to deliver such product to the buyer within 30 days thereafter.

(f) The failure to have access to a quantity of the advertised product at the advertised price sufficient to meet reasonably anticipated demands.

(5) Representing that the services or advice of a person licensed to practice medicine or of a person certified as an audiologist will be used or made available in the selection, fitting, adjustment, maintenance or repair of hearing aids when that is not true; or using or incorporating in any title or designation the words, "doctor" "clinic", "clinical audiologist", "audiologist", "State licensed clinic", "State registered", "State certified", "State approved" or any other term, abbreviation, or symbol, or wearing any costume, which would give the false impression that one is being treated medically or audiologically or that the registrant's services have been recommended by the State.

(6) Canvassing from house to house or by telephone, either in person or by agents, for the purpose of selling a hearing aid, without prior request from the prospective customer.

(7) Selling a hearing aid to a person under the age of 18 or to any person in a mental institution, hospital, nursing home, convalescent home, or like institution, unless there is present in addition to the registrant an adult person who is not a business associate of the registrant.

(8) Permitting another to use ones certificate of registration or temporary certificate of registration.

(9) Representing, advertising, or implying that the hearing aid or repair is guaranteed, without a clear and concise disclosure of the identity of the guarantor, the nature and extent of the guarantee, and any conditions or limitations imposed.

(10) Failure to supervise a trainee as required by Sections 9 & 10 of this Act or to accept responsibility for the actions of a trainee relating to the fitting and selling of hearing aids.

(11) Using any advertisement or other representation which has the effect of misleading or deceiving purchasers or prospective purchasers in the belief that any hearing aid or device, or part or accessory thereof, is a new invention or involves a new mechanical or scientific principle when such is not the fact.

(12) Representing, directly or by implication, that a hearing aid utilizing bone conduction has certain specified features, such as the absence of anything in the ear or leading to the ear, or the like, without disclosing clearly and conspicuously that the instrument operates on the bone conduction principle, and that in many cases of hearing loss this type of instrument may not be suitable.

(13) Stating or implying that the use of any hearing aid will restore hearing to normal, or preserve hearing, or prevent or retard progression of a hearing impairment, or any other false or misleading or medically or audiologically unsupportable claims regarding the efficacy or benefits of a hearing aid.

(14) Representing or implying that a hearing aid is or will be "custom-made", "made to order", "prescription made", or in any other sense especially fabricated for an individual person when such is not the case.

(15) Directly or indirectly giving or offering to give, or permitting or causing to be given, money or anything of value to any person who advises another in a professional capacity, as an inducement to influence such person, or to have such person influence others, to purchase or contract to purchase any product sold or offered for sale by the registrant or to influence any person to refrain from dealing in the products of competitors.

(16) Violation of any of the Trade Practice rules for the Hearing Aid Industry, as promulgated by the Federal Trade Commission July 20, 1965, or as amended.
(17) Such other acts or omissions as the Department may determine by regulations to be unethical conduct.

SECTION 17. TRIAL PERIOD: RECEIPT TO BE FURNISHED PURCHASERS OF HEARING AIDS

Every registrant who sells a hearing aid shall provide for a trial period of the instrument by the purchaser, and shall deliver to the purchaser a receipt which shall contain all of the following information:
(1) The name, address, and signature of the purchaser.
(2) The name, address of the regular place of business, the number of the certificate of registration, and the signature of the registrant.
(3) The make, model, serial number, purchase price, and the date when the manufacturer first produced the same model.
(4) Whether the hearing aid sold is new, used or rebuilt.
(5) If the hearing aid is (or has been represented to be) guaranteed, there shall be a clear and precise statement of:
(a) the identity of the guarantor and the manner in which the guarantor will perform under the guarantee (such as total or partial refund, repair, or exchange);
(b) the nature and extent of the guarantee;
(c) any material conditions or limitations in the guarantee which are imposed by the guarantor, and
(d) if a guarantee made by the registrant is not backed up by the manufacturer, the fact must be made clear that the guarantee is offered only by the registrant.
(6) The complete terms of the sale, including the terms of the trial period, an itemized account showing individually the goods and services, and the individual prices for them, that go to make up the total amount charged the purchaser.
(7) The name and address of the Department, with a statement that complaints which may arise with respect to the transaction may be submitted to it.
(8) In type no smaller than the largest type contained in the receipt, the following statement:
The purchaser was advised at the outset of relations with the undersigned hearing aid dealer that any examination or representation made by the dealer in connection with the fitting and selling of the hearing aid described in this receipt is not an examination, diagnosis, or prescription by a person licensed to practice medicine, audiology, or otolaryngology in this State.
(9) A copy of the written recommendation and findings of the otolaryngologist, or otologist and/or audiologist who examined the purchaser, and issued clearance for a hearing aid, showing the type and degree of hearing disability involved (such as conductive, sensorineural, or mixed hearing loss.)
(10) A statement precisely setting forth all representations made by the hearing aid dealer about the dealer's tests, test results, and recommendations, and about the special benefits of the hearing aid purchased, together with written materials supporting such claims or representations.

SECTION 18. MINIMAL EQUIPMENT AND PROCEDURES

The following minimal equipment and procedures as prescribed by the Department with the advice of the Council shall be used in connection with the fitting and sale of hearing aids:
(1) Minimal equipment shall include:
(a) Access to a selection of hearing aid models, and hearing aid supplies and services complete enough to accommodate the various needs of hearing aid users, such as: an adequate stock of hearing aids, including an appropriate selection of receivers; an adequate selection of accessories; and access to facilities for making ear molds; and any other supplies required by the Department.
(b) Satisfactory facilities for the personal comfort of customers.
(c) A sound treated testing room.
(d) Pure tone audiometer which shall meet the American National Standards Institute specifications for diagnostic audiometers and which shall be calibrated and recorded at intervals established by the rules and regulations of the Department.
(e) Speech audiometer for determining the most comfortable listening level and speech discrimination.

(2) Minimal procedures shall include:

(a) Pure tone audiometric testing by air and bone conduction to determine the degrees and types of hearing deficiency. Masking as required.

(b) Appropriate testing to determine speech discrimination, speech reception threshold, most comfortable sound tolerance level, and selection of the best ear for maximum hearing aid benefit. Selection of an instrument that will best compensate for the degree of loss and tolerance level and provide a frequency amplification curve that will give the best speech discrimination possible.

(c) Final fitting of the aid insuring physical and operational comfort.

(d) Keeping a complete retail price list showing all hearing aid models for all prospective customers to examine.

(e) Keeping records on every customer to whom the registrant renders services or to whom he sells a hearing aid. Such records shall be preserved for at least seven years after the sale of the first hearing aid to the customer. If other hearing aids are subsequently sold to that customer, cumulative records must be maintained for at least seven years after the latest sale of an aid to that customer. The records which must be available for Department inspection will include:

(1) Copy of each receipt executed in connection with the fitting and sale of each hearing aid.

(2) A complete record of tests, test results, and services;

(3) Customer's case history;

(4) Any correspondence specifically related to the customer or the hearing aid or aids sold to the customer.

SECTION 19. RENEWAL OF CERTIFICATE OF REGISTRATION OR TRAINEE TEMPORARY CERTIFICATE OF REGISTRATION

(1) Every certificate shall expire on December 31 of the year in which it is issued. On or before October 1, of each year, the Department shall mail to each registrant or trainee an application for renewal of the certificate. The application shall be completed by the registrant or trainee and sent to the Department, accompanied by the annual renewal fee. Every application shall request a record of the current educational material the applicant has studied and the educational classes the applicant has attended in the hearing health field since last receiving a certificate of registration or a trainee temporary certificate of registration. Upon approval of the application by the Department, the Department shall send the applicant a renewed certificate issued under the seal of the Department.

(2) In the case of an application for renewal of a trainee temporary certificate of registration, the sponsor registrant shall sign a statement reporting the progress being made by the trainee. No trainee temporary certificate of registration shall be renewed for any person who has had the opportunity to take three consecutive examinations.

(3) A certificate which has not been renewed by January 1 of any year shall be automatically suspended after a 30-day grace period, until such time as the registrant or trainee shall pay the regular fee plus a delinquency fee of $——— for each month or fraction of a month that such person failed to register provided, that after a period of 3 months the certificate shall be automatically cancelled.

SECTION 20. PROCEDURE FOR HANDLING COMPLAINTS AND DENIAL, SUSPENSION, OR REVOCATION OF CERTIFICATES OF REGISTRATION OR TRAINEE TEMPORARY CERTIFICATES OF REGISTRATION PUBLIC HEARINGS

(1) Any person who wishes to make a complaint against a registrant or a trainee or an applicant for a certificate of registration under this Act shall reduce the complaint to writing and file it with the Department within one year from the date of the action (or failure to act) upon which the complaint is based. If the Department finds, after such investigation as it deems appropriate, and after advice of the Council that the charges in the complaint and the circumstances justify a public hearing to determine whether or not a certificate of registration or a trainee temporary certificate of registration shall be denied, suspended or revoked, the procedure set forth in this section shall be followed.

(2)(a) No certificate shall be denied, revoked or suspended except after written notice by registered mail to the applicant or registrant or trainee, setting forth the particular reasons for the proposed action, furnishing a copy of the complaint, and explaining the right to a public hearing if demanded by the applicant or registrant or trainee.

(b) Any applicant or registrant who desires such a hearing shall, within twenty days after service of notice, request the hearing in writing, sent to the Department by registered mail.

(c) If an applicant or registrant or trainee requests a hearing, the Department shall fix a date, time, and place for the hearing and shall notify the applicant or registrant or trainee accordingly. Such notice shall be either personal notice or notice by registered mail, and shall be served at least 30 days before the date set for the hearing.

(d) If no request for such hearing is made, the Department shall forthwith deny, revoke, or suspend the certificate.

(3) For the purposes of such hearing, the Department shall have the power to require the production of books, papers, and other documents, and may issue subpoenas to compel witnesses to appear. Witnesses shall be entitled to the same per diem and mileage allowance as witnesses in the county courts of record in this State, payable out of the Hearing Aid and Devices Trust Fund, established by Section 12 of this Act. The customary rules of evidence used in court proceedings shall not be applicable to the hearing.

(4) If the Department determines from the evidence and proofs submitted that the accused has been guilty of violating any of the provisions of this Act, or any of the regulations promulgated by the Department pursuant to this Act, the Department shall, within thirty days after the hearing, issue an order refusing to issue or renew, or revoking or suspending (as the case may be) the certificate. The order shall include the findings of fact and the conclusions of law made by the Council. A copy of the order shall be sent to the accused by registered mail. The records of the Department shall reflect the action taken by the Department on the charges, and the Department shall preserve a record of the proceedings in a manner similar to that used by courts of record in this State.

(5) The final order of the Department in the proceedings for denial, suspension, or revocation of a certificate shall be subject to appeal to and review by, an appropriate court of record in the county where the accused resides, or in which the accused's principal place of business is located.

(6) The Department shall send a copy of the complaint and a copy of the Department's final order to the Attorney General, for purposes of information in the event the accused pursues a court appeal, and for consideration as to whether the violations are flagrant enough to justify prosecution.

NOTE: If a particular State has an Administrative Procedure Act add the following subsection:

(7) Insofar as applicable, the provisions of the Administrative Procedure Act of this State shall govern the hearing and appeal set forth in this section.

Section 21. Attorney General and County Prosecuting Attorneys

The Attorney General of this State and all county prosecuting attorneys are authorized and directed to assist the Department in the enforcement of the provisions of this Act.

Section 22. Penalties

Violation of any of the provisions of this Act, or of any of the regulations promulgated pursuant to this Act, shall constitute a misdemeanor, punishable upon conviction by a fine of not more than five hundred dollars, or imprisonment for not more than ninety days, or both.

Section 23. Action To Enjoin Violations of Act Bond Not Required

(1) Upon violation of any of the provisions of this Act, or of any of the rules and regulations promulgated by the Department pursuant to this Act, any judge of any court of record in any county where such violation occurs is empowered to restrain and enjoin any person or his agents or representatives from further violating any of such provisions. Such injunctive relief may be granted upon the application of the Department, and shall not be barred by reason of any administrative or penal proceedings had or pending involving the same charges. No bond is required when such injunctive relief is sought.

(2) Nothing contained in this section shall preclude any other person from obtaining injunctive relief or damages on account of a violation of this Act.

SECTION 24. ESTABLISHMENT OF ACADEMIC COURSES IN THE FITTING, SELLING, AND SERVICING OF HEARING AIDS

(1) The Department of Education, with the advice and assistance of the Department of Health and the Advisory Council is authorized and directed to establish within educational institutions, financed in whole or in part with public funds of this State, formal courses of instruction to enable eligible students to become qualified hearing aid dealers and fitters. Minimum enrollment requirements shall be good moral character and the educational equivalent of successful completion of a four year course in an accredited high school.

(2) Such course shall consist of a minimum of the equivalent of 30 semester hours, as computed by accredited colleges and universities in this State. The semester hours shall be devoted to classroom instruction and practical application as the Department of Education and the Department of Health shall find most effective.

(3) Insofar as feasible, the Department of Education shall provide for the utilization of present faculty members teaching audiology, physics and physiology and may permit employment of such additional full or part-time instructors as may be necessary to carry out the purposes of this section.

(4) One year after instruction is commenced under this section, the Department of Education is authorized to modify the number of semester hours and subjects of instruction required for successful completion of the course to reach the number of hours and subjects necessary for an associate in arts degree, or its equivalent.

(5) Successful completion of the course provided herein shall qualify the student to take the examination required by this Act, without complying with the requirements of the trainee apprenticeship course described in Section 10.

(6) The Department of Education and the Department of Health are authorized to promulgate such rules and regulations, not contrary to the laws of this State, as may be necessary to carry out the purposes of this Section.

SECTION 25. EFFECTIVE DATE

This Act shall take effect immediately.

ITEM 2. LETTER FROM ELMA GRIESEL,* COORDINATOR, RETIRED PROFESSIONAL ACTION GROUP, SUBMITTING SUMMARY REPORT ON THE RETIRED PROFESSIONAL ACTION GROUP STUDY: PAYING THROUGH THE EAR: A REPORT ON HEARING HEALTH CARE PROBLEMS, TO SENATOR CHURCH, OCTOBER 12, 1973**

DEAR MR. CHAIRMAN: In testimony before this Committee regarding "Hearing Aids and the Older American," the Retired Professional Action Group reported on its sixteen-month study of the hearing health care system. Shortly after the hearings, on September 30, 1973, our report, *Paying Through the Ear: A Report on Hearing Health Care Problems*, was released to the public.

The contents of this 300-page report are relevant to several issues explored at the hearings; therefore, we are submitting for the hearing record a summary of its major topics. In addition, we have taken the opportunity to present specific information which relates to the testimony of witnesses representing the Hearing Aid Industry Conference and the National Hearing Aid Society.

The staff of RPAG feels strongly that hearing aids should be provided under the Medicare system. As you are aware, this proposal was adopted by participants at the 1971 White House Conference on Aging.

The industry maintains that hearing aid dealers should be providers of service under any Government program—and particularly under Medicare. However, after many months of study, RPAG concluded that the industry delivery and service system does not work in the public interest and should not be the basis of any Government program financed by taxpayers.

The public should not support a system in which the industry would profit further from tax dollars until (1) consumers first obtain medical clearance and/or clinical audiological testing prior to the purchase of an aid, (2) the public can be assured that dealers entering the program are fully qualified to serve the public, and (3) the marketing and pricing system is changed so that reasonable charges are made for hearing aids and services.

*See statement, p. 3.
**For industry statement on RPAG study, see p. 160.

Since 1968, unqualified persons and substandard facilities have been permitted to provide nursing home care to patients under Medicare. The public continually faces deplorable situations caused by these crucial errors. Surely, we must learn from those experiences and establish a hearing health care system under Medicare which will result in high quality services as well as financial benefits.

We appreciated the opportunity to testify before this committee. Your consideration of our proposals, and our report which speaks for hearing-impaired consumers, will also be greatly appreciated.

Sincerely,

ELMA L. GRIESEL.

Attachment.

A SUMMARY REPORT BASED ON THE RETIRED PROFESSIONAL ACTION GROUP STUDY: PAYING THROUGH THE EAR: A REPORT ON HEARING HEALTH CARE PROBLEMS, OCTOBER 1973

The Retired Professional Action Group (RPAG), an organization supported by Ralph Nader's Public Citizen, is composed of a group of older and younger persons working on public interest issues that primarily affect older people. From February 1972 to September 1973, RPAG conducted an extensive investigation of the hearing health care field. Many of the problems and abuses in the field had previously been identified and described by concerned and experienced consumers, researchers, writers, and newspaper reporters. In addition, two Senate committees had previously explored issues of concern to the public.

During the course of this study, RPAG staff in Washington, D.C., and volunteers in four States, had interviews and correspondence with more than 1,000 persons—including hard of hearing individuals and their families, medical ear specialists, audiologists, hearing aid dealers, manufacturers, and people working with the hearing impaired. Over 600 hearing impaired people and 250 professionals working in this field, of whom 2 percent were handicapped themselves, returned questionnaires for RPAG's use. RPAG contacted more than 200 State, local, and Federal offices of Medicaid and Vocational Rehabilitation, State offices of the attorney general, State consumer groups, and hearing aid dealer licensure boards. One older hearing aid user* served as full-time consultant to the RPAG staff from February 1973 to the completion of the study.**

One and one-half years of intensive research has well-equipped members of RPAG to make serious proposals for change in the hearing health care delivery system. Thus, statements by the industry that the staff was not qualified to understand the unique problems of the hearing impaired and make recommendations for change is not validated by the facts.

NUMBER OF PEOPLE AFFECTED

At least 8½ million American people suffer from a hearing loss severe enough to warrant amplification. But only 2½ million people wear hearing aids. Persons aged 65 years and over are most often affected. At a press conference, September 29, 1973, at which the report was released, Mr. Nader stated that "The over-

*By mutual agreement with the Coordinator of RPAG, in February 1973, Mr. Joseph Wiedenmayer, a volunteer who had directed the study, left RPAG. Comments regarding Mr. Wiedenmayer's work at RPAG are necessary only because (1) the industry has made public statements which erroneously indicate that the resignation of Mr. Joseph Wiedenmayer is of relevance to the objectiveness of the final report, (2) Mr. Wiedenmayer made statements to the press, reported in newspapers around the country, September 30, 1973, that the report "would do more harm than good." His remarks were made before he or any other person had time to review the report in detail, (3) it seems clear that the majority of hearing impaired consumers who have been in contact with RPAG, would disagree with Mr. Wiedenmayer's evaluation of a report which was written in their behalf, and (4) the personal negativism and publicity tactics of Mr. Wiedenmayer and industry representatives should not be alllowed to influence positive action in behalf of consumers. Mr. Wiedenmayer also stated to the press that he left RPAG because he disagreed with "the philosophy and approach of the Nader organization." In an initial letter requesting to work for Mr. Nader, Mr. Wiedenmayer stated explicity, "It is time for Nader to do an exhaustive investigation of all facets and all groups concerned." However, in several months after he joined the staff it became evident from Mr. Wiedenmayer's activities and correspondence that he maintained such friendly personal relationships with people in the industry that he could not conduct a comprehensive and objective study in which hearing impaired consumers would be of primary concern. Despite significant evidence that the consumer was not being served fairly and adequately in the marketplace, Mr. Wiedenmayer expressed that he did not wish to write a report which would be critical of the current hearing aid delivery system to the extent that it would interfere with the free enterprise system. Mr. Wiedenmayer also disagreed with the staff that all hearing impaired older people should receive benefits from Medicare to alleviate physical and financial difficulties which resulted from their hearing loss. In addition, RPAG's approach to public interest work could not offer Mr. Wiedenmayer the continual personal recognition and support to which he had become accustomed in his distinguished career.

**For statement by Mr. Wiedenmayer see pp. 101–104.

riding concern of this report is that millions of people who need amplification devices don't get them. This is really a severe indictment of the industry which is only willing to serve its customers at its prices rather than to develop a system that would significantly broaden the market."

Despite the large number of people who are not served, the industry claims to take pride in the increase in the number of hearing aids sold over the past 5 years. On September 11, Mr. James Ince, executive secretary of the Hearing Aid Industry Conference (HAIC), stated that he found "A gratifying consumer endorsement in the fact that the number of hearings aid units sold increased from 400,000 in 1968 to 600,000 in 1973." Mr. Ince concluded, "We believe this is a clear message of consumer satisfaction and support."

However, RPAG contends that three important factors must be considered in relation to this increase: (1) The number of hard of hearing people in society is increasing, so that to be meaningful the number of units sold must be expressed as a percentage of the number of hearing impaired people as compared to previous years, (2) "units" rather than "customers" are referred to as the measurement, and it is well known that there is an increasing incidence of two hearing aids being sold to one individual; and (3) third party sources of funding such as Medicaid and Vocational Rehabilitation have enabled people to buy aids for whom money to purchase was previously a significant barrier. Therefore, Mr. Ince's conclusion of consumer satisfaction and support did not take into account all of the facts involved.

On September 29, Mr. Nader made the following important remarks related to the claims of the industry that "consumers are satisfied": "This is an area of consumer abuse that hasn't had much visibility largely because it has exploited people who are older or institutionalized, and therefore not particularly aggressive, or people who feel that they have gotten back some of their hearing and are happy with the results, but don't really know how much better hearing health care and prices could be. Hearing aid dispensing occurs in a context—typical in the medical field—where the consumer neither has the access to the facts, nor the rights to exercise them, nor anybody to represent him, and is in a prone-trust position that diminishes any kind of consumer sovereignty."

THE BALTIMORE STUDY

In 1962, hearings by the Senate Committee of the Judiciary Subcommittee on Antitrust and Monopoly, and the Senate Special Committee on Aging in 1968 revealed that many injustices exist in the provision and cost of hearing health care. RPAG's study revealed that 5 and 10 years after those hearings, the same conditions exist.

In order to obtain firsthand information about the practices of hearing aid dealers, RPAG recruited eight volunteers to participate in a consumer study in Baltimore, Md. The volunteers included six women and two men, whose ages ranged from 68 to 82.

The Baltimore study was not designed to use scientific methodology with highly trained researchers in controlled settings. However, it was designed so that it could be duplicated easily by other consumer groups and the results compared. The purpose was to depict what can happen daily to ordinary consumers when they rely on hearing aid dealers who are primarily profit-motivated and secondarily providers of service.

The volunteers first had their hearing evaluated by clinical audiologists at the hearing and speech center at Johns Hopkins Hospital. They then took dealers up on their offer of a free hearing test and visited 13 different dealers who had been chosen at random by RPAG from the city telephone directory. Contrary to industry statements, these individuals did not use aliases and did not feign a hearing loss.

In 42 percent of the visits to dealers, hearing aids were recommended by dealers when audiologists had recommended none. None of the 13 dealers performed the adequate range of audiometric tests which are necessary to accurately describe hearing loss. None of the dealers conducted tests in a soundproof environment. In several instances, dealers made false statements to the volunteers such as, "Wearing a hearing aid will restore your hearing to normal," and, "a hearing aid will stimulate the nerve endings and prevent deterioration of hearing."

The Baltimore study gave RPAG volunteers many of the same types of experiences as the hundreds of consumers who had written to RPAG during

1972–73. Also during 1972–73, a series of consumer investigations by the Minnesota Public Interest Research Group, The Minneapolis Star, Wayne State University, and the Detroit Free Press, revealed findings similar to those of RPAG volunteers.

The results of the Baltimore study illustrate what can happen to a consumer seeking services from a hearing aid dealer chosen at random from a telephone directory. Consumers cannot be assured that they will receive high quality services, that a recommendation for an aid is warranted, or that the price of an aid is justified unless they have been first served by reliable health professionals who have referred them to a competent, honest dealer or unless they have reliable information with which to evaluate the services they receive.

Hearing impairment can be a serious health problem which can significantly affect one's mental and social well-being. There can never be justification for a hearing aid to be sold to a person who does not need one, or cannot use one, or for anyone needing a hearing aid not to have one. There is no excuse for misrepresentation or falsehoods, and there is no place for high pressure commercial salesmen in the health delivery system.

INDUSTRY REACTION TO THE RPAG STUDY

The industry trade associations, the Hearing Aid Industry Conference and the National Hearing Aid Society, have together contributed $100,000 to combat RPAG's report, of which $50,000 was allocated to a public relations firm, Hill and Knowlton, Inc. Throughout the summer of 1973, the industry released a series of news releases designed to offset the RPAG report. Each congressional office and press received a packet of "Fact Sheets." On June 13, 1973, 3 months before the RPAG report was released, a precanned press statement was sent to every dealership in the country so that it could be submitted to local newspapers the day RPAG's report was released. According to the industry:

> The allegations in the Nader report on the hearing aid industry are not only factually wrong but materially harmful to millions of Americans who badly need help with hearing problems.
>
> The effect of the viciously based Nader report is to drive these handicapped people back into their encroaching caves of silence and mute despair.

At the time of the release, no industry person had read the report, nor had it even been completed. A letter for every dealer's use was also prepared and distributed so that the dealer could send it to each of his customers. These items are exhibited in full in the RPAG report.

These industry efforts, in addition to the use of Joseph Wiedenmayer's resignation from RPAG, represent an obvious attempt to draw attention away from the contents of the report before consumers and other interested and concerned individuals have had a chance to read it. An NHAS representative remarked on September 11, 1973, at the Senate hearings that "Scaring the hearing impaired is not the road to encouraging them; that the RPAG report is the very antithesis of public education; and that it is intended as an 'expose'."

On the contrary, the RPAG report is the very essence of consumer education. It was written by a consumer group in order to offer individual consumers, concerned groups and voluntary associations, the public, and Government officials, up-to-date information on the complex problems in the industry, to offer recommendations on how to achieve optimal benefits in a malfunctioning marketing and health care system, and to make specific recommendations for action and change which will benefit consumers.

At the hearing, industry representatives, in ignorance of the contents of the report, made numerous misstatements about the report such as "The sensationalism and headlines which these reports receive shake the confidence of those millions of elderly hearing impaired people who are already embarrassed to take proper measures to obtain competent care." In reality, sensationalism is exemplified by the hearing industry press releases and other pronouncements. As Mr. Nader remarked, September 29, 1973: "The hearing aid industry is highly sensitive to criticism as their draft release prepared in response to a report they had never seen nor read indicates. That always is a syndrome of sensitivity that camoflauges real problems in an industry. Those individuals who in reality may have hurt the hearing impaired are those who made public prejudgments of it without a thorough study of the contents."

LACK OF MEDICAL ATTENTION

It is unconscionable that so few hearing impaired people receive medical or other professional attention. Seventy percent of people who buy hearing aids go to a dealer first instead of to a doctor or an audiologist, or to someone trained and supervised by these health professionals. This is primarily because of dealer accessibility and the use of high pressure sales tactics and heavy unsubstantiated advertising by the industry. While there are 15,000 dealers and salesmen, there are only 2,100 audiologists and 5,100 medical ear specialists in the United States.

At the Senate hearings, an official of NHAS discounted the need for prior clearance by a physician. He said: "I do not really think a physician can see all the people that we see," and anyway, "it is within our realm of a nonmedical person to recognize things that should be referred to physicians. If we get him first, we refer him to a doctor."

In a special interview for trade association magazine in the spring of 1973, the president of the American Council of Otolaryngology stated that a hearing loss is a medical problem, and that hearing impaired individuals should seek services from medical specialists. He stated that the profession is equipped and willing to handle such cases.

Most dealers have little or no formal training in hearing and cannot screen customers for medical clearance. One example of what can happen if prior medical clearance is not obtained is contained in a letter from one consumer to the Commissioner of the Indiana State Board of Health:

"I hope that you will take time to read this very thoroughly. It is very important to me and to thousands of other hearing impaired persons in Indiana and the Nation. I will relate my experience with bilateral hearing loss, which is caused by an inherited factor and which corresponds almost exactly with my brothers experience along the same line.

"About 5–6 years ago I began to notice a hearing loss which gradually became worse to the point that it became necessary for me to do something about it. My position is such that I must attend board meetings and other meetings and was becoming unable to participate at all.

"I went to a hearing aid center in Seymour, Ind., in the fall of 1971 to see about the possibility of getting a hearing aid. It occurred to me that I probably ought to check with a doctor again. Once, while talking with a doctor who I admire and respect very much, he indicated that I should go to a hearing aid dealer, so basically that is why I went to the hearing aid company.

"At the hearing aid company I was given several what seemed like sophisticated hearing tests, knowing nothing of hearing tests per se I was impressed. The man testing me informed me that I had about 50–60 percent loss in each ear and that although a little conduction problem existed, the largest portion was nerve damaged. For one thing this statement was discouraging and caused some anxiety on my part because I knew that nerve damage was irreversible. He also informed me that there was no surgery for the nerve damage and that an aid would be the only solution, a special aid made up to fit my specific tone range loss.

"I borrowed the money and purchased the aid and was overjoyed with the results because I could now again participate in board meetings, hear friends and so many other things that it was unbelieveable. I wore the aid for approximately 9–10 months. I made a mistake in the summer of 1972 when going swimming in a lake, I forgot to remove my aid. It remains on the bottom of the lake.

"I was very depressed and immediately began to relive my preaid days of hearing problem frustrations. I didn't do anything for a few days. One day while at work a volunteer, who is a doctor's wife, suggested that I should see an eye, ear, nose, and throat man in Columbus, Ind. . . . before I decided to purchase another aid. I did see this doctor and was referred by him to the hearing evaluation clinic at the Indiana University Medical Center. The results of this evaluation proved to be the opposite of the hearing aid salesman's 'findings' with two subsequent stapectomeys being performed which turned out to be like small miracles to me. Now, except for a small loss in high frequency sounds my hearing is normal.

"Now my question to you is this, why does a State licensing board let this kind of a situation exist, why is there no legislation requiring an audiological examination before a hearing aid can be sold. Had my hearing been

impaired further because of infections from the hearing aid, you can rest assured that this would not be an informal letter.

"It seems to me that it is your responsibility as a State health overseerer to educate, inform, and protect the people from this situation. Please, I beg of you, do something.

"To begin with, any tax moneys handled through State programs, Veterans Administration, Vocational Rehabilitation Division, Medicare, etc., should very definitely have a stringent requirement of a full audiological examination by a formally trained, degreed audiologist.

"I, for one, will be following this situation closely and will be contacting agencies and legislators to see why it is not now done or why no plans are being made."

This is not an isolated instance, as other case histories in RPAG office will verify. Dr. Charles Giffin, an ENT who practices in Indiana, wrote RPAG: "To say that they (the hearing impaired) do not need to see a physician is to place ourselves in the dark ages of medical practices. With the ever increasing volume of knowledge, related to hearing, it is becoming more and more important to make a valid, early diagnosis, in order to initiate proper therapy. Sensori-neural hearing losses, that would have been passed over with the comment 'there is nothing we can do' a few years ago, are now being subjected to a battery of tests that may show the presence of diabetes, syphillis, tumor, etc. In the hands of an unqualified person, these hard of hearing people would be destined to a life of unnecessary difficulty and/or death itself."

Dr. Giffin analyzed the tests performed by dealers as follows: "We would have to say that, in the vast majority of cases, the test results provided by the hearing aid dealer are not reliable. The test performed by most hearing aid dealers; would be comparable to the screening tests that are used in the public schools, which have a high instance of overfailures."

It is common for medical professionals, particularly general practitioners, to refer their clients to dealers instead of to clinical audiologists. The deference of doctors to dealers has been attributed to the fears of some physicians that audiologists might usurp some of their territory. Also many are not knowledgeable about the special services that audiologists can render. In contrast to most ENT physicians, most general practitioners have not had specific training about the ear, hearing loss, and hearing aids.

LACK OF PRESCRIPTION FOR HEARING AIDS

At the present time, no way has been developed to scientifically predict which aid is best, as is the case with corrective lenses. At the Senate hearings, the industry used this fact to justify the dealer's ability to test. Mr. Marvin Pigg stated, "Hearing aid selection and fitting is an art and not a science. At this time, hearing aids cannot be prescribed, but must be individually and skillfully fitted."

Audiologists are generally highly trained and qualified to perform a hearing aid evaluation (HAE). The selection process takes 1 to 2½ hours in a soundproof room utilizing a wide range of tests. Dealers may spend only one-half hour or less selecting a hearing aid, in rooms which are not impervious to outside noises, using only one or two of the major tests.

At the hearings it was particularly interesting to note that the industry brought a professionally trained audiologist to explain audiograms to the committee while at the same time they stated that anyone can be trained in 2 to 7 days to perform hearing evaluations. The testimony of Mr. Terry S. Griffin, an industry representative, is reflective of the kind of distortions and oversimplifications used by the industry to justify the use of untrained people in hearing aid evaluations.

A primary point to be made with regard to Mr. Griffin's testimony is that the basic pure tone air and bone conduction test he refers to, when performed in nonsoundproof conditions, can result in: (1) faulty diagnosis of some degree of hearing loss when in fact none exists, (2) faulty diagnosis of a nontreatable hearing loss when in fact treatable (conductive) loss exists. The latter occurs because noisy test environments cause bone conduction thresholds to be more affected than air conduction thresholds. Any air bone gap which exists (including medically treatable loss) could therefore be hidden.

While it may be true that any intelligent person could be trained to push buttons on an audiometer in 2 days, it is obvious that this is not all that is

necessary in order to perform accurate, reliable, valid hearing evaluations. A thorough hearing aid evaluation includes the intake and interpretation of relevant case history information, the performance of basic pure tone testing and speech audiometry as well as the interpretation of results, the counseling of the hearing impaired, and the determination of the need for the requirements of a hearing aid.

INDUSTRY PROMOTION AND SALES PRACTICES

Dealers are in a position fraught with conflict of interest. By the very nature of their business their major interest must be making money and fulfilling sales quotas imposed by the manufacturers. If they do not, they may lose their product line. Most are pressured to sell an aid regardless of the client circumstances or need. In a sales manual of one major manufacturer, a story on "How to Recharge Your Battery" was related by a salesman. The story, which is proclaimed in the manual to be true, goes as follows:

E. How To Recharge Your Battery

HOW IMPORTANT IS YOUR ATTITUDE?

We are in a business of attitudes. Attitudes are contagious. They affect your customers and your prospects. But—most important of all—they affect you.

Here's how one of today's leaders who has reached a supervisory position tells his own story:

"I thought I 'had it made.' I was well trained by this time—and was selling 23 people a month.

"My supervisor agreed it wasn't bad. 'But,' he said, 'Do you realize, Bob, that 19 of these 23 sales are time payments? Only four were cash sales? You could reverse that if you tried.'

"I disagreed—strongly. I was working in a poor neighborhood where employment was off. The people just didn't have the money. They told me they didn't have it and anyway I knew they didn't have it. You could tell that from the way they were living. Well, my supervisor and I talked until four o'clock in the morning. By that time I could see he had a point. I agreed that *maybe* they *did* have the money—for something they wanted very much—like a Beltone. And I agreed to try for more cash sales.

"The next month I sold 17 people and 15 of those 17 were for cash. Part of that change was probably due to a different way of selling. What I mean is—I *asked* for cash. But mainly I did it by changing my own attiude—my own inner conviction that they really could pay cash.

"Well, I was pretty happy when I talked to Jim, my supervisor, at the end of the month. He said that 15 cash sales out of 17 was 'OK'—but he asked me, 'Do you realize that out of those 17 sales, Bob, you haven't one binaural?'

"I explained patiently to this impossible man that these people were poor people—*very* poor. They had trouble enough paying for one unit, let alone two. It wasn't hard to see what they could afford by looking at their homes, their standard of living. It wasn't hard to see how happy they were to be able to get one unit—and how very impossible it was to buy two. Maybe later on—but not now. They told me that. Practically every one of them said they could get one now, but two was out of the question. 'If you don't believe me, Bob,' I said, 'you come with me next week.'

"That night we stayed up late again—this time until almost five in the morning. We talked about a lot of different things—the importance of hearing—the things that motivates a man and makes him able to 'afford' something or not afford it. But mostly I began to realize the benefits of binaural fitting and that a monaural fitting, in most cases, was a job only half done. I guess I changed my attitude about binaural because. . . .

"That next month I sold 19 people and 7 of them bought binaural. Now, it is true that the percentage of cash sales dropped somewhat from the previous month, but I could see I was making more sales—with less effort. And that I liked!

"I didn't wait for the next meeting with my supervisor. I phoned him this time and bragged that I had learned how to make more money with less effort. And I was tickled pink to admit he was right.

"Know what he said this time? Maybe you guessed it. He asked me only one question: 'How many of your sales were users?' I can't say I was very polite when I growled at him that none were to users and—'so what?'

"We didn't stay up to talk about it at night this time. He went with me instead—right into the field. We spent one entire day—about ten hours—prospecting for users. Users, users, users—they did seem to be just about everywhere. And I began to see the light about selling users.

"The next month—I had 21 sales and 13 were to users!"

(The above is a true story. Name of consultant on request.)

As in many other sales industries, manufacturers conduct sales contests offering free European trips and prizes to high volume dealers. Commercial interest results in hard-sell tactics and other aggressive behavior totally inappropriate when a medical device is being dispensed. A large majority of complaints sent to RPAG were from individuals who had been tested and sold an aid in the home. Studies indicate that from 60 percent to 90 percent of sales are made in the homes, depending on the rural or urban nature of the market place.

It is true that aggressive salesmanship can persuade a person to buy an aid (or two) however, a person who is not psychologically ready to wear an aid, will not. In order to sell aids to reluctant buyers, the industry makes inflated and exaggerated claims for the benefits from wearing an aid.

In July 1972, the FTC asked 12 leading manufacturers to substantiate certain advertising claims the FTC found suspect. In June 1973, the charges against the manufacturers were made available for public inspection. (Although the material FTC disclosed excluded its own evaluation of the charges, and therefore was of little value to prospective hearing aid purchasers.) After the FTC Bureau of National Advertising completes its investigation, FTC Commissioners will decide whether or not to issue complaints against these manufacturers, ordering them to cease and desist certain advertising practices.

The industry philosophy justifies aggressive sales behavior and high saturation advertising. This was expressed by Mr. James Ince: "Hard of hearing people need persuasion and demonstration of how they can be helped. The dealer aggressively serves this need as a businessman, and that is the principal reason we were able to help more people every year. The opposite, of course, is that when the initiative for getting help is left to the hearing impaired, they do not get it—even if the aid is given away. In European government systems in which aids are free, use on a popular basis is often lower than in our present U.S. system where most hearing aids need to be paid for by the user."

This comparison of hearing aid use in the United States with that in European countries contradicts available information. Research indicates that individuals do take advantage of free hearing help in countries where such plans are available. For example, statistics indicate that 43 percent of the total hearing impaired Swedish population own a hearing aid. The U.S. Embassy in Copenhagen reports that about 33 percent of the population that needs a hearing aid use them, compared to 25 percent in the United States.

In Australia, consumption of aids has increased since the country started to supply them under a government program in 1968. This program supplies health care to two-thirds of the older population. There has been a growth of 117 percent in the number of hearing aids distributed over 6 years. According to L. T. Upfold from the Commonwealth Acoustic Laboratories in Sydney, "This indicates that there are far more people in need of aids than will purchose without government assistance." He stated further, "I believe there is a snowball effect similar to that seen previously with eyeglasses. The more hearing aids provided the more people are willing to wear them, producing a constant demand and increase as aids become more available." Mr. Upfold estimated that 5 percent of the aged population has a hearing loss, and 3 to 4 percent of the aged population already wears an aid in Australia.

At the Senate hearings on September 10 and 11, 1973, industry representatives made claims that they had supported licensure laws for hearing aid dealers since the early 1960's. In reality, as the RPAG report reveals in detail, the industry was firmly opposed to licensure proclaiming that it would be an interference in the free enterprise system and an unfair restraint on ethical dealers. Although the rationale was never explained, industry's strongest pitch against licensure was that it would be detrimental to the consumer. Action by the Federal Trade Commission in 1965 forced change in industry attitudes. In July 1966, following promulgation of the trade practice rules for the hearing aid industry, the FTC proposed that each State initiate efforts to enact a law to regulate the

activities of hearing aid dealers. The Commission issued a proposed uniform law developed by the Council of State Governments. Even though the proposal was based on the weak Oregon law, it unleashed a new tirade of industry protests.

Delegations from NHAS and HAIC met separately with FTC staff to express opposition to the bill. In a February 1967 meeting, NHAS was somewhat appeased after being told that FTC would consider a model bill from the trade association. HAIC went into the meeting with FTC "unalterably opposed" to licensing. But in the March 1967 issue of The Hearing Dealer, the chairman of HAIC's legislative committee reported that HAIC was advised in the meeting that "the handwriting was on the wall" and that they could either fight licensure as it came up in each State or they could determine what industry wanted in a good bill and push hard for consideration of the industry viewpoint.

By December 1967, the trade association journal reported that a "solid, reasoned and united position now exists in the industry regarding licensing." An alliance between NHAS and HAIC had resulted in the formation of an industry model bill. The resolution that accompanied the bill urged State groups, "to take all necessary measures to protect the hearing aid dealer's right to pursue his role in the selection, sale and fitting of hearing aids." It added that NHAS "will vigorously encourage, support and assist any State association in achieving proper legislation and oppose oppressive, restrictive and otherwise unreasonable measures." Consequently, in State after State industry has continued to fight consumer protection provisions which they interpret as being restrictive and detrimental to the hard of hearing public.

A thorough RPAG review of the licensure laws in 33 States revealed that the majority are virtually carbon copies of the industry model, which offers little protection to consumers.

One exception is a law passed in Minnesota. After an intense struggle against the industry, Minnesota public interest groups influenced the Minnesota legislature to pass a bill in May 1973 requiring that "no hearing aid shall be sold by a person in this State except upon the prescription or other written and signed recommendation of an authorized person who is neither employed by, or in a business relationship with, a seller of hearing aids." The term "authorized person" includes an audiologist, otolaryngologist, otologist, or licensed medical doctor. A weakened compromise of the original bill now permits "adults" under 60 years who are legally competent to be exempted from this provision if they sign a waiver acknowledging that they have been provided a copy of the law and that the law has been read aloud to them by the hearing aid vendor. The law specifies certain medical conditions which, if detected by the vendor, require the consumer to consult with a medical doctor or audiologist. There are no waivers of this provision.

An illustration of the hostile reaction of the industry to Minnesota's bill and consumer activities is offered in the following letter issued by Electone, a manufacturing company, to hearing aid dealers, July 9, 1973:

> Dear Friends: We have lost the State of Minnesota. Yes, that's just what I said. The State of Minnesota has passed a law which in part makes it unlawful for the hearing aid dealer to test and sell hearing aids. Your State could be next. Most of you already know that Nader's Raiders have left their damaging effect on Baltimore, Md., and are now working in California to supposedly release some more damaging news about our industry. . . . Are you willing to fight for a free enterprise system of government? . . . For the freedom of running your own business? If you are willing to join with me, Electone will help you fight this battle. Together we can stop Government controls of our industry and shut up Nader's Raiders for good. . . . This mailing is being distributed to over 2,200 hearing aid dealers across the country . . . The impact of this great number of hearing aid dealers joining together can stop the decaying of our industry . . . can prevent your city or State from receiving bad publicity from Nader . . . can stop the politicians from enacting laws that will prevent you from fitting and selling hearing aids, which is your livelihood. If you want to join the forces of over 2,200 hearing aid dealers across the country, return the enclosed self-addressed card indicating your interest, and Electone will show you how to win this battle.

Licensure of hearing aid dealers has falsely promoted dealers and salesmen as professionals qualified to serve the hearing impaired. According to NHAS statis-

tics in the summer of 1973, only 2,114 (approximately 15 percent) of the 15,000 retail personnel have received minimal training to maintain any standards of competency, education, ethics, and reliability. These 2,114 dealers are certified by their trade association, NHAS, and have completed the society's 20-week home study course. Professional analysis of the course revealed that each chapter, which requires about a week of study, presents material requiring a full semester for students of audiology.

Even though the training of dealers has always been obviously inadequate, 29 States have licensed dealers and salesmen through a "grandfather clause." Thousands of dealers were given licenses without having to take an exam to test their competency to evaluate a hearing loss or to recommend a medical device. In most States, people with minimal requirements for age, character, and secondary education, can become "trainees" and immediately begin to service customers and sell aids. In many States, trainees do not have to work in the same office as their "supervisor." Trainees are not required to advise their customers that they are trainees.

Illustrative of the lack of consumer protection is the fact that in only five States must dealers refer consumers (of any age) to doctors if there are indications of medical problems. In only 12 States is it a punishable offense to sell a hearing aid for a child without prior medical exam and clearance.

There is little to no enforcement of the licensing laws which exist. In most States authority rests with a board composed mainly of hearing aid dealers. Most consumers have no idea where to go for information or where to make complaints. Nearly all complaints are handled "informally" by board members so that there is rarely any action taken against dealers even when the complaint justifies it. Although the person with whom the dealer "settles" a complaint informally may be satisfied, the dealer is not necessarily deterred from repeating the same act again.

THE HIGH COST OF HEARING AIDS

A major reason people don't wear aids is their high cost. An RPAG survey of 429 individuals showed that 73 percent of hearing impaired people, their families and workers in the hearing health field, thought prices of aids too high. The average retail price of an aid is $350 to $400, an obvious economic barrier to lower-middle and low-income groups. But most older people fall in this economic strata. People aged 65 and over, living alone or with nonrelatives, were found to have median incomes of $2,199 in 1971. The U.S. National Center for Health Statistics survey showed that 36 percent of hearing impaired people had incomes under $3,000 and more than 69 percent had incomes under $7,000. In response to a question asked by Senator Percy "What is the lowest cost instrument that can be obtained of fairly decent quality?", Mr. Ince replied that some manufacturers maintain a line of aids for this purpose, and that one major manufacturer advertises an aid for $85. According to Mr. Ince, "I think $85 buys a serviceable aid." The implication is that there are a number of $85 serviceable aids on the market. On the contrary, Zenith is the only brand name company that offers an aid for under $200, although smaller less well-known companies do. Further, the $85 aid is a body-type aid, suitable for only a small percentage of persons of hearing loss. For example, in 1972, only 14 percent of the total sales were body-type aids. What is important is the number of companies providing the popular behind-the-ear type aid at under $200.

There are about 500 different models of hearing aids an the market. Some manufacturers produce as many as 60 models even though there is little need for so many variations. This proliferation makes it very costly to manufacture. It also leads to consumer confusion.

Large markups of 200–300 percent occur at retail. The marketing system of the hearing aid industry is mainly responsible for the high prices of hearing aids, since manufacturers and dealers operate in a manner that creates and maintains artificially high prices. At present, there are about 50 separate companies marketing hearing aids in the United States. Four companies (Beltone, Zenith, Dahlberg, and Qualitone) controlled over 50 percent of the dollar value of shipments in 1970, according to the FTC. Beltone alone captured 20 percent of the market that year. Eight companies controlled over 70 percent of the sales volume, leaving only 40 percent of the market to be divided among the 40-odd smaller companies.

MANUFACTURERS' RELATIONSHIPS WITH DEALERSHIPS

According to the FTC, manufacturers' activities tend to be "oppressive, coercive, unfair and anticompetitive." In 1972, the FTC cited major manufacturers—Beltone, Dahlberg, Maico, Radioear, and Sonotone—for engaging in anticompetitive activities that violate section 5 of the Federal Trade Commission Act. They alleged that these manufacturers (1) usually require their dealers to sell hearing aids within assigned geographical areas; (2) insist that dealers deal exclusively in their hearing aids; (3) "fix, establish, control and maintain" retail prices at which dealers sell their hearing aids; (4) prohibit dealers from dealing with potential customers outside their territory; and (5) require dealers to submit to manufacturers names and addresses of their customers. Two companies, Sonotone and Radioear, have signed consent orders; three are taking their cases to court.

At the hearings, Mr. Ince was asked by Senator Percy, "How much control do the manufacturers actually exercise over the dealerships? Are there contracts? Are there restrictive dealerships? Do dealers handle more than one manufacturer's products? Do they handle several brands?" Mr. Ince's reply ignored reference to the FTC action, of which he was well aware. He said, "No, there can be no restriction of the type you are talking about, Senator."

Experiences of one major dealership, Master Plan Service Co., indicate differently. Master Plan has attempted to provide low-cost products to consumers in eight cities in the midwest, Washington, D.C., and Chicago. Products range from $99 to $199. But Master Plan has had great difficulty in persuading name brand manufacturers to supply products to them. When one company, Norelco, offered to supply their aids, its other dealers threatened to boycott, so the company withdrew its written offer. After 2 years of supplying Master Plan, another large company, Oticon, also withdrew, writing that supplying Master Plan would "disrupt our distribution set up" and that Oticon needed to "protect and create reasonable growth in our business." (After exposure at the Senate hearings, and on the day the RPAG report was announced to the press, Oticon began supplying its products to the embattled firm.)

This example shows how manufacturers and dealers cooperate to prevent the offering of lower-priced products to consumers. If manufacturers attempt to supply a lower-priced retail outlet, the dealers threaten not to carry its line. Reports to RPAG from other low-priced dealers indicate that this form of coercion is not unusual.

One reason for FTC's ineffectiveness in dealing with the hearing aid industry is the impotence of the trade practice rules for that industry. The rules (now called "industry guides") were promulgated in August 1953 and subsequently revised. One leading industry spokesman claims to have written them. These rules have been noted more for their breach than for their observance. The FTC has adopted stronger trade regulation rules for industries producing such items as sleeping bags, tablecloths, and lubricating oil. Clearly FTC regulation of hearing aids is more crucial.

HIGH PRICES ARE BUILT INTO THE SYSTEM

Manufacturers lure dealers by offering them attractive profit margins, thus dealers have no desire to offer lower priced products. The manufacturers suggest retail prices at a level which guarantees the most inefficient dealer a comfortable living. This obligates dealers to manufacturers and makes them responsive to manufacturers' marketing demands. At the same time, it discounts the possibility that manufacturers can support lower retail prices.

Even when dealers buy products for an extremely low cost, they tend to sell it for high prices. RPAG volunteers did comparison shopping on an aid which was offered at wholesale for $33. Although a few dealers sold the aid for $100 to $200, the majority of retail prices quoted by dealers were from $300 to $400.

Since from 50 percent to 65 percent of aids are sold to users, the industry is forcing thousands of customers to pay for something they don't want, or may not need, or may wish to seek elsewhere—service. By tying in service costs (estimated at $100) to the price of the aid, dealers force customers to pay for service regardless of need or desire. Most customers need fewer services after experience with their first aid but when they purchase new aids they must pay full cost nonetheless.

In order to uphold high prices of aids, the industry frequently makes the statement, "you get what you pay for." If this is true then previous user-consumers should not be subsidizing what another consumer gets. RPAG found a few dealers who are doing quite well on a "fee for service" pricing system.

HEARING AIDS AND SERVICE DISTRIBUTION BY TRAINED AUDIOLOGISTS

For several years a major controversy has waged between the industry and professionals in the field of audiology over the proposal that audiologists dispense hearing aids. It seems inevitable that some audiologists will begin to make aids available through their offices, although they will not sell them directly. One prototype that would allow audiologists to dispense aids and to maintain their professional objectivity would be the establishment of a nonprofit corporation in every major city managed by a board of directors comprised of local hearing impaired consumers and representatives of groups providing services to the deaf and hard of hearing. Such an organization would purchase aids directly from manufacturers and make them available to hearing and speech clinics, practicing audiologists and other hearing health groups. Billing would be handled by the corporation. The organization would be a central depot for repairs, similar to the system used by the Veterans Administration. Audiometric assistants could be hired to work under the auspices of the audiologists to handle fitting and selling of aids and other technical services now performed by dealers.

THE VETERANS ADMINISTRATION AND HEARING AIDS

The VA dispenses hearing aids at approximately $200 per veteran, including a professional examination, aural rehabilitation classes, travel expenses, and the National Bureau of Standards (NBS) hearing aid performance testing program. This program is universally attacked by dealers and manufacturers because it buys hearing aids directly from the manufacturer, bypassing all but a few dealers.

After World War II, the VA became a major purchaser of aids for veterans and requested the NBS to develop test data on which to base buying decisions. Each year since 1956, NBS has tested aids for the VA. Published reports of VA testing procedures, publicly available since 1970, are the result of Consumer Union's lengthy battle to force release of information from VA and NBS. The information VA released to the public was not entirely useful even to professionals in the field, let alone consumers. CU did make a price-quality analysis of the VA testing results and made it available to the public in the May 1971 issue of Consumer Reports.

CU did not continue this service to the public. In any event, the VA information is of little help to consumers since product quality is significantly uneven in the marketplace. All one can derive from the VA material is that certain hearing aids meet quality specifications when tested by NBS. Even this information is questionable because VA picks up the hearing aids from the manufacturer. In order for the evaluation program to be entirely objective, VA should begin to pick up aids anonymously and at random from retailers. The evaluation information could then be useful to consumers. Otherwise, there is no assurance that the aids picked up by the VA at manufacturers are not specifically built to meet VA testing specifications.

MINIATURIZATION OF HEARING AIDS

The industry could do more to improve sound quality in hearing aids if they did not put their efforts into building miniaturized hearing aids. Tiny units cannot effectively amplify lower frequency or base sounds without considerable distortion. Not only is sound more distorted in smaller aids but the instrument is harder to operate by older and arthritic people. It is difficult to assess to what degree the public's desire for miniaturized aids has been manipulated by the industry. Advertisers have certainly enhanced the consumer's fear of wearing an aid that might be visible. At any rate, most experts agree that future development of aids should be directed toward increased fidelity rather than further reduction in size. One engineer with considerable experience with hearing aid microphones advised RPAG that hearing aids will most likely improve over the next several years, provided there isn't pressure to continue to make them smaller.

RPAG LETTER TO THE FOOD AND DRUG ADMINISTRATION

In its attempt to influence changes in the hearing health care field—particularly related to the quality of hearing aids, RPAG has written the following letter to Alexander M. Schmidt, M.D., Commissioner of the Food and Drug Administration:

RETIRED PROFESSIONAL ACTION GROUP,
Washington, D.C., October 2, 1973.

ALEXANDER M. SCHMIDT, M.D.,
Commissioner, Food and Drug Administration,
Rockville, Md.

DEAR COMMISSIONER SCHMIDT: The Retired Professional Action Group (RPAG) is composed of older and younger professionals working for improvements in conditions affecting our older population. For the past 16 months, this group, which is supported by Ralph Nader's Public Citizen, has conducted an investigation of the hearing health care delivery system, with particular emphasis on how hearing aids are delivered to older people.

Some of the major problems our study revealed are: (1) That hearing aids often do not meet quality and performance specifications; (2) consumers are often given inappropriate and false information on what the hearing aids (as a medical device) can do; and (3) instruments used for performing hearing aid evaluations are not kept in proper calibration. In addition to the direct and harmful effect this has on individuals, Government programs such as Medicaid and Vocational Rehabilitation annually spend millions of tax dollars providing hearing aids and services to beneficiaries.

It is clear that hearing aids fall under the FDA definition of a device in section 201 (321) of the Federal Food, Drug and Cosmetic Act as amended 1938;

> Instruments, apparatus, and contrivances including their components, parts and accessories, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or other animals, or to affect the structure or any function of the body of man or other animals.

At the 1968 Senate hearings, Leo J. Gehrig, M.D., Acting Surgeon General of the United States, said that "Hearing aids are devices subject to all of the adulteration and misbranding provisions of the Federal Food, Drug and Cosmetic Act. Thus truthful labeling, adequate directions for use, and compliance with professed standards are required."

RPAG maintains there are indications of violation of the misbranding provisions of the Federal Food, Drug and Cosmetic Act, as it relates to hearing aids. It is time for the FDA to take action based on the following findings and recommendations:

Uneveness of product quality is a serious problem in the hearing aid industry. One aid may differ substantially in performance from an aid of the identical model and brand. At a 1971 meeting of the National Academy of Sciences/National Research Council Committee on Hearing, Bioacoustics and Biomechanics. Dr. Raymond Carhart from the University of Michigan said:

> A question of immediate importance involves determination of the quality of instruments currently being made available on the commercial market. I am sure that at present many a hearing aid buyer gets an instrument that is substantially inferior to the prototype of that instrument that was developed by the company's engineering department.

The New York League of the Hard of Hearing, one of the few organizations with the expensive analyzer equipment necessary to test the electroacoustical nature of hearing aids, reports that about 50 percent of the aids they test do not work the way the manufacturers' specification sheets indicate.

Dr. Robert M. McLaughlin, associate secretary for audiology affairs at the American Speech and Hearing Association, and until recently at the University of Michigan Hearing and Speech Clinic, says his experience is that one out of nine aids don't work the way their specification sheets claim they do. Other audiologists complain they cannot be assured that when the client buys the aid they have recommended, that it will perform the same as the clinic's test aid. Therefore, many clinics such as the University of Michigan and Wayne State University order the aid from the dealer, request that it be sent to the clinic where it is tested on analyzer equipment to make sure it has the necessary performance characteristics. Other clinics insist that a client come back to him with the dealer's model so the client can be tested with it on.

It is not only the audiologist who cannot trust the product quality, but also the dealer who cannot be sure he is buying a good product from the manufacturer. One dealer estimated that about 10 percent of his aids ordered from the manufacturer arrived in a defective condition. Dealers cannot afford the analyzer equipment which would protect them from purchasing defective or misbranded merchandise.

RPAG believes that one of the causes of poor product uniformity is lack of mandatory industrywide standards of acceptable performance. The American National Standard Methods (ANSI) for measurement of electroacoustical characteristics of hearing aids are merely "guides" for "describing practical and reproducible methods of determining physical performance characteristics" of hearing aids. The HAIC standard method of expressing hearing-aid performance, used by most companies, is also voluntary and set low so that most manufacturers are able to meet the minimal standards.

In essence, specification sheets boast of what the aid can do instead of giving objective, scientific information necessary for evaluating the aid. Since they are primarily "advertisements" for the aid, it is not surprising, as one engineer told RPAG, that manufacturers omit information not complimentary to the product.

A major reason why hearing aids do not meet performance specifications is that there are several ways to tamper with machines and statistics used for measuring hearing aid performance. Audiologist Angela M. Loavenbruck, Ph. D., associate professor at Catholic University describes some of them:

(a) In testing distortion levels, very low input (noise) may be used. The result is low distortion levels. If the input was like noise levels experienced in everyday situations, the distortion would be much greater.

(b) It is very common for frequency response curves to be artificially smoothed out, giving incomplete information about the gain and an inaccurate impression about the distortion.

(c) The aid can be tested by using volume dial settings much lower than might be used by a wearer. If the volume dial were turned up, more distortion would appear. The aid should be measured at the volume setting that will be used by the customer.

Thus, specification sheets distributed to dealers and hearing and speech clinics by manufacturers may give little accurate or useful information about how the aid actually performs. One physicist estimates that most of the models have no specifications other than frequency response. According to experts in the field, other specifications that should be indicated are:

(1) Maximum deliverable pressure, or output (dB) which should fall within a ±3 dB of the specified gain at major frequencies.

(2) Frequency response curves (Hz) which should be within ±3 dB.

(3) Maximum gain which should not be over 132 dB.

(4) Total harmonic distortion: ±2½ percent is the ideal allowance; ±5 percent is detectible to the user but not objectionable; at present, ±10 percent is allowable.

Another problem identified by experts in the field is that audiometers are not properly calibrated, particularly in hearing aid dealer establishments. The need for continual calibration of audiometers is widely recognized in audiological circles. The result of an improperly calibrated audiometer is an inaccurate evaluation of hearing loss.

A 3-year Public Health Service survey by the University of North Carolina's Audiometric Calibration Center begun in 1964 found the entire sample of audiometers used in North Carolina to be in unsatisfactory calibration. Moreover, 46 of 100 audiometers tested had not been calibrated from the day they were purchased.

It is apparent that FDA needs stronger authority in order to take positive, aggressive action to implement regulations on hearing aids and other medical devices. RPAG is supporting current legislative efforts which would give the agency the authority it needs.

In the meantime, FDA could be taking action on several issues in order to protect the consumer. RPAG recommends the following:

(1) We understand that devices are now being cataloged in three classifications. RPAG contends that hearing aids fall in the category which specifies that those devices for which in order to reduce or eliminate unreasonable risk or injury or illness, it is appropriate to establish reasonable standards to assure safety and effectiveness.

(2) The FDA should join with appropriate Government agencies to review the HAIC and ANSI standards for hearing aids, strengthen those provisions which are lax, and require that all manufacturers adhere to them. In particular the Veterans' Administration and the National Bureau of Standards should be involved for they have already built a wealth of information and expertise regarding hearing aids.

(3) FDA should require that the industry state performance characteristics on the specification sheet for each hearing aid, and that the testing of hearing aids be measured by the ANSI methods for measurement. If measuring methods for certain characteristics are not found in these standards, the manufacturer should be required to file a copy of the measurement procedures used, until such time as standards are established.

(4) An FDA review committee should develop a standard format for the presentation of performance data on specification sheets which would permit a meaningful comparison among different makes and models of hearing aids.

(5) Hearing aid manufacturers should be required to establish and maintain records and make reports which will give the FDA sufficient information necessary to regulate misbranding, efficacy and compliance with performance and safety standards.

(6) RPAG believes that all new models should be subject to premarket clearance for adequate labeling. Premarket clearance by the FDA would prevent the marketing of unnecessary products, and suppress the extravagant claims of product performance made by dealers and manufacturers. This is important because there are approximately 500 models of hearing aids on the market already, many of which are similar products. Each year this industry markets new models the way the car industry markets new cars. Although the hearing aid manufacturer claims there are "new improvements," typically the change is only a cosmetic one—in the size or styling of the aid.

(7) All facilities using audiometers should be required by the FDA to file periodic statements that their instruments are in proper calibration according to ANSI standards.

(8) Because of common misleading claims by dealers, FDA should require that the instructions accompanying each hearing aid carry two disclaimers: (1) This hearing aid will not restore your normal hearing; (2) this hearing aid will not prevent further hearing loss. These disclaimers would deter hearing aid dealers from making such claims which are not supported by audiological or medical research, and would provide the consumer with important information relevant to the purchase of a hearing aid.

(9) In addition to directly protecting the public through involvement in the testing and regulation of hearing aids, FDA should generate and fund a wide-scale educational effort to increase public recognition of the fact that hearing aids are not consumer appliances to be sold indiscriminately by commercial salesmen, but are medical devices which should be purchased only after medical and audiological evaluation.

The FDA has taken very little action in the field of hearing aids. In the late 1960's, FDA did respond to a suit brought by the State of Pennsylvania against the hearing aid "Hushtone." The FDA accused the company of making false and misleading claims for the product, and of selling it in interstate commerce.

One FDA official told an RPAG investigator in April 1973, that hearing aids are a low priority consideration because they are considered "economic" in nature. This excuse from the Federal agency regulating drugs, cosmetics and foods is indefensible. The FDA claims as first priority devices which have life-or-death impact, such as heart pacemakers, intrauterine devices, kidney dialysis units and impact resistant lenses. Although not the cause of life-or-death situations, hearing aids do have a profound psychological effect on older people who are otherwise often physically and emotionally isolated.

Representatives from RPAG met with Mr. David M. Link and Larry R. Pilot of the office of medical devices in August to discuss these problems. They expressed an interest in making reforms that are within the scope of present FDA authority. They advised RPAG that an ENT review panel would be formed to classify hearing aids and other devices relative to otolarynology. We asked to be notified when the panel is formed so that the names of qualified physicians can be submitted to serve.

We urge that you give RPAG recommendations your most serious consideration and that you allocate resources to monitor the situation we have described. Please advise us of the action you intend to take on these recommendations.

Sincerely,

ELMA L. GRIESEL, *Coordinator.*

RPAG LETTER TO THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

There are several activities which should be pursued by HEW. The activities recommended in the following letter should result in better services for the consumer. In addition, they are relevant issues to explore in the consideration of the provision of hearing aids and hearing health care services through the Medicare program:

RETIRED PROFESSIONAL ACTION GROUP,
Washington, D.C., October 2, 1973.

HON. CASPAR WEINBERGER,
Secretary, Department of Health, Education, and Welfare,
Washington, D.C.

DEAR SECRETARY WEINBERGER: The Retired Professional Action Group (RPAG) is composed of older and younger professionals working for improvements in conditions affecting our older population. For the past 16 months, this group, which is supported by Ralph Nader's Public Citizen, has conducted an investigation of the hearing health care delivery system, with particular emphasis on how older people are served in that system. According to a U.S. Public Health Service report, "Human Communication and its Disorders: An Overview," the annual direct costs to the Nation for the education, management, and compensation of the hearing impaired is estimated at $410,445,000. The estimated annual deficits in earning power among the acoustically impaired is $1,250 million. These costs do not reveal the price in human suffering which results from communication disorders.

On September 10–11, 1973, the Senate Special Committee on Aging, chaired by Senator Frank Church, held hearings regarding "Hearing Aids and the Older American." An important aspect of these hearings concerned the feasibility of providing hearing aids through the Medicare program. Every person who testified urged that hearing aids be so provided. Several witnesses, including RPAG, emphasized that the industry delivery system does not work in the public interest and should not be the basis of any Government program financed by taxpayers. There is need for great change in the present delivery system, and for emphatic support for alternative systems which benefit consumers.

Our study uncovered many problems which relate to programs in the Department of Health, Education, and Welfare. It is significant that abuses regarding hearing aids and Medicaid have been discovered in New York and Indiana during the last 2 years. Thousands of dollars worth of hearing aids were ordered by hearing aid dealers for patients in nursing homes who did not need them. These stories were noteworthy and reported by the press, although there is no evidence that the reports initiated investigations in other areas. RPAG found that the records of HEW lump all prosthetic devices into one category, making it impossible to obtain national figures on how much is spent through the Medicaid program on hearing aids and hearing health care services. This information is also difficult to obtain from the States.

In a survey of all State Medicaid and State Vocational Rehabilitation programs, we found that most of these State programs purchase each individual aid directly from a local hearing aid vendor. Discounts range from 10 percent to 30 percent, with most States reporting 20 percent discounts. This is astonishing when one compares it to the VA program which purchases hearing aids in bulk from the manufacturers at much lower prices. In addition, the VA quality control program assures that each veteran receives an aid that meets quality specifications. In the Medicaid and Vocational Rehabilitation programs, few States have requirements or practices which assure such control.

The VA does not purchase aids until they have been evaluated by the National Bureau of Standards through special testing procedures developed many years ago. Although the National Bureau of Standards is set up to provide this service, no other Federal agency uses it and the general public does not receive any direct benefits from the program.

Noise pollution is a significant problem in our society. Exposure to noise of sufficient intensity for long enough periods of time can produce detrimental changes in the inner ear and can seriously decrease the ability to hear. The incidence of hearing loss, with all of its physical and mental health ramifications, will continue to increase. Except for programs now developing regarding occupational health and safety, there are no Government efforts to advise the public of the dangers involved.

Indeed, the public is quite ill-informed about hearing loss and hearing aids. Our society still tends to perpetuate negative and unrealistic attitudes about hearing loss and hearing aids. Only 2 of 8½ million people estimated to need aids actually purchase them.

In view of the significance of these problems, RPAG urges that you authorize that the following action be taken:

(1) Review and evaluate hearing aid purchasing policies under programs such as Vocational Rehabilitation, Medicaid, the Office of Education, and the Children's Bureau for the purpose of establishing an HEW purchasing system similar to that of the VA system. (See chapter IX and chapter VI, pp. 4–7.)

(2) Develop a system through which the results of the hearing aid quality evaluation program of the National Bureau of Standards can be utilized by all agencies which purchase hearing aids. (See chapter IX.)

(3) Require that no hearing aid be purchased with Federal funds until a proper evaluation by the qualified person is made. (See chapter II.)

(4) Request that the General Accounting Office conduct audits of State Medicaid hearing aid purchasing programs. (See chapter VI, pp. 10–12 and chapter IV, p. 8.)

(5) Conduct a nationwide information campaign to advise the public of preventive and corrective measures to take regarding hearing loss and hearing aids and encourage the use of amplification.

We have written Commissioner Schmidt of the Food and Drug Administration advising him of the necessity for action by the FDA. A copy of that letter is enclosed.

Hearing loss is a handicap that seriously affects the physical and mental health of an estimated 8,500,000 Americans. The majority of those affected is composed of older individuals, thousands of whom live on fixed incomes and who face isolation, despair, and poor health.

By taking action on these proposals, the Department of Health, Education, and Welfare could have a significant positive impact on the lives of Americans suffering from this handicap. We would appreciate a response to our proposals at your earliest convenience.

Sincerely,

ELMA L. GRIESEL, *Coordinator.*

RPAG MODEL LICENSURE LAW FOR HEARING AID DEALERS*

As part of its study, RPAG developed its own model law for licensure of hearing aid dealers. This bill, which has been sent to every State Governor and State attorney general, represents a careful study of the laws of the 38 States and other models. RPAG found that no existing licensure law, model law, or proposed law gives consumer protection and consumer interests the emphasis that the subject merits.

RPAG contends that optimal service to a hearing impaired person includes a visit to a medical ear specialist prior to the purchase of a hearing aid. An audiological examination by the specialist, by a certified clinical audiologist, or by someone trained and supervised by these professionals is most desirable.

A thorough study of any State health resources should indicate whether or not this optimal provision regarding professional health care is possible. If a shortage of health personnel exists, the State should look for other means of fulfilling this goal. For example, the establishment of mobile hearing health clinics or the provision of screening services for hearing loss in public health clinics and senior citizen centers.

The primary consideration is that any person giving a hearing evaluation and determining whether an aid is necessary, should be able to do so objectively without the conflicting desire of wanting or needing to sell a hearing aid.

In any event, this bill does not exclude the hearing aid dealer. It leaves the decision of referral to a qualified hearing aid dealer or a clinical audiologist to the medical ear specialist. Of most importance, the bill requires the hearing aid dealer to meet high standards of conduct and expertise which will mean better services and protection for the consumer. It offers the means for the hearing aid dealers to upgrade their skills and increase their knowledge through education and training. Both the public and the hearing aid industry should demand no less.

*See p. 73.

Among other protective provisions the model bill would require that the ultimate authority and responsibility for administration of the law be vested in a State department of health, or its equivalent, instead of an independent board composed primarily of hearing aid dealers. The bill would require the keeping of adequate records available for public inspection. All hearing aid dealers would be required to take the prescribed examination which would be developed by a qualified hearing health care team and not based on the NHAS home study course as are most State examinations.

The bill would provide for adequate and improved supervised training of persons desiring to serve the hearing impaired and for protection of consumers by requiring identification of trainees as such.

It would require periodic inspection of facilities and calibration of audiometric testing equipment, and minimal procedures and equipment, including a sound-treated testing room. Each customer would be given a trial period after purchase of an aid during which time the aid could be returned for adequate reimbursement and service. The dealer would be required to give the consumer specific information about the sale of the aid and would require that the dealer keep complete records on every customer.

In addition the bill would prohibit a dealer from canvassing from house to house or by telephone without prior request from the customer. Special protection would be offered in connection with sales to persons in institutions such as nursing homes, and to minors. Dealers would be prohibited from making common false or misleading or medically unsupportable claims about the efficacy or benefits of a hearing aid.

CONSUMER ACTION

Repeated appeals from the consumer for better service and lower cost aids have reached only a minority of hearing aid dealers and very few manufacturers. This disregard of consumer needs is the driving force behind the desire for consumer participation in an attempt to change the hearing health care delivery system. RPAG is convinced that citizen action is imperative to: (1) Counteract activities of the industry trade associations which flout the public interest; and (2) activate static, self-serving voluntary and professional groups to serve the public interest. Some important activities for consumers are listed below:

(1) Review and evaluate any existing State licensure law for hearing aid dealers to determine how effectively it protects the consumer.

(2) Evaluate the State agency or board to determine how effectively it deals with consumer complaints, and how well it regulates the activities of hearing aid dealers.

(3) Monitor local dealers, audiologists, and physicians to determine the extent and quality of their services.

(4) Organize a campaign to educate the public about hearing loss and to dispel negative attitudes about wearing a hearing aid.

(5) Organize to amend the existing State law, if necessary, or to adopt a State law if one doesn't exist.

(6) Determine what information is available regarding services for the hearing impaired.

(7) Develop a directory of State resources if one is not currently available.

(8) Organize to actively support and promote provision of hearing aids and related services under Medicare.

CONSUMER GUIDE SECTION

The RPAG report contains a consumer guide section which offers consumers specific information about hearing aids and hearing health care.

ITEM 3. STATEMENT OF JOSEPH E. WIEDENMAYER, CHEVY CHASE, MD., TO SENATOR FRANK CHURCH, SEPTEMBER 14, 1973

My credentials are: Retired U.S. career Foreign Service Officer after 22 years abroad (1943–1965); special assistant and consultant to the Alexander Graham Bell Association for the Deaf (education of deaf children), 1965–1972 (retired); director, hearing disability study of Ralph Nader's Retired Professional Action Group, April 1972–February 1973 (resigned).

Presently, associate editor of the American Council of the Blind's *Braille Forum* Magazine and national chairman of council's committee for deaf-blind adults; national chairman, A. G. Bell scholarship committee for deaf college students.

Born hard of hearing; worn hearing aid for over 50 years. Became legally blind shortly before retirement from the Department of State (1965). But not totally deaf or completely blind. Hearing aid and low vision lens are of considerable benefit.

My interest in hearing aids, audiology, otology, and otolaryngology is on behalf of deaf and hard of hearing people. Consequently, I have sought the best possible professional and commercial services for the Nation's hearing impaired and more recently, the visually handicapped also, but I am not a doctor or dealer. However, I believe I know what these handicapped people desire and need to function better. A great many of them are my personal friends. (Over 50 percent of the hard of hearing are over 65.)

Improvements in the business and professional sectors are needed and some are overdue. Yet, existing services and products in general should not be unjustly criticized. Nor, should one sector of the hearing health field continue fighting another. Selfish motives by any sector can only serve to confuse, if not frighten, the very people we all wish to benefit—the hearing impaired.

May I say, parenthetically, that I could never have entered and remained in the highly competitive diplomatic service without a hearing aid—even the less efficient instruments of many years ago.

Listen, let's not rush to change radically a hearing aid distribution system which for the most part is practical, efficient, and also cooperative with professional sectors. Rather, let's build on the structure and improve it. One way is to require State licensing for every hearing aid dealer and every clinical audiologist. While this has already begun, it is not required in all States. And, in addition to the training and certification of dealers, sales consultants, and audiologists, all three categories should serve an apprenticeship of 3 to 6 months in the field at a dealership or clinic—before consulting or testing or selling any hard of hearing person, without on-the-spot supervision by a more experienced person. But even better—the larger dealer could have a university trained audiologist on his staff!

Let's not frighten or confuse the hearing handicapped by blanket accusations against an honest industry which through its research, development, and sales efforts has enabled millions of people to function better and enjoy fuller lives.

Listen, selling the hard of hearing on using the first hearing aid always precedes any testing, fitting, and dispensing. Only dealers can sell. Doctors and audiologists sit back and wait for patients or clients who have already decided they need help or they would not be in his office in the first place.

Listen, those who never earned a dollar in private business do not appreciate what it costs to do business and are not qualified to criticize or change it—particularly when the business involves products and services for the handicapped. Great caution in modifications is necessary.

Listen, nobody can calculate the true value of a prosthetic or corrective device which improves one's hearing or sight or mobility. Ask a deaf man what it would be worth to hear music and speech again. Ask a blind lady what she would pay to see her children, or, just ask a business executive who is hard of hearing what his hearing aid is worth to him in terms of his ability to function well. Yes, hearing aids and accessories are expensive, but one way to get the prices down is by increasing sales volume which means more consumer education than now. Only about 15 percent of the hard of hearing wear a hearing aid.

Listen, the vast majority of hearing aid users have never consulted anybody except a doctor and a dealer about a hearing aid and are doing well with it. Some might be doing still better with a better fitting or adjustment of their instrument, but at least they have been sold and they are much better off than before without one.

Listen, audiologists with doctorates represent a new and needed profession established after World War II. Audiologists are experts in hearing and speech problems of the deaf and hearing evaluation in their clinics, but only when the client walks in voluntarily or is recommended by a doctor (medical). For some people the added expense in fees to an audiologist is very worthwhile. Yet, in a Nation of some 15 million people with defective hearing there are only about 1,800 practicing clinical audiologists, and nearly all are located in hospitals or universities, as compared with 4,500 dealers, plus, the thousands of hearing aid

specialists. What then does a potential hearing aid buyer do in a city far removed from an audiologist's office. He goes to a dealer. Even in cities with audiologists, a dealer still provides hearing tests and other services, the cost of which is included in the hearing aid price.

But, listen again, there are some people who should not be sold any hearing aid at all without being examined first by an ear doctor, and, nobody should get his first hearing aid without seeing an ear specialist first to find out if there are possibilities for corrective measures, e.g., medicinal or surgical. Or, there could be a physical condition which would make a hearing aid inadvisible. If the doctor has no audiometric facilities to test and evaluate hearing he can recommend an audiologist to determine the extent of hearing loss and make the appropriate recommendation for the hearing aid fitting and then referral to two or three dealers. If the loss is found insufficient to warrant a hearing aid, the client will be told by the doctor or audiologist. Of course a dealer can also determine if an aid is really needed, but there are borderline cases for the first hearing aid so the consumer should not let an overzealous salesman sell what is not needed. This is another reason for seeing a doctor first.

Listen, whether a hearing impaired person consults a doctor, audiologist or dealer—only the hard of hearing person himself can decide which hearing aid model and which adjustment he likes and hears best with. Nobody else can do that for him. So in the end, it is always up to the one who has to live with his hearing problem for the rest of his life. Doctors can only prescribe and predict—and though with accuracy—they cannot tell how sounds are going to sound to the patient.

Listen, for the many people whose personal vanity or proscrastination prevents their use of a needed aid—any quality instrument is better than none at all. Obviously, it's best to get the right one at the outset, yet the main thing is to get one.

Let's make it easier and less expensive to get hearing help and not erect too many barriers or red tape to self help.

Let's improve advertising which is too often misleading. Let's improve ethics and qualifications of all dealers, but let's also remember that the vast majority of dealers are in business to stay in it and therefore it is to their advantage to make and keep satisfied customers. No doctor or audiologist knows the hearing aid user personally as well as the dealer who communicates with his customers much more frequently.

Let's make Medicare and Medicaid help for hearing aids available to those who are physically qualified and in financial need of such assistance and through the present dealer distribution system—but not provide it to those who can afford to pay for services and products. Consumer education rather than free aids is the best way to induce most people to wear a hearing aid.

Let's have doctors, audiologists, and dealers work more closely as a hearing health team—not as competitors—for they are not. Each category has a role to play in its own field and need not overlap.

Finally, and most important of all—let's ask the hard of hearing what they want instead of having normally hearing people tell them what they should have.

JOSEPH E. WIEDENMAYER.

ITEM 4. ADDITIONAL STATEMENT OF JOSEPH WIEDENMAYER, FORMER DIRECTOR, RPAG HEARING DISABILITY STUDY, SUBMITTED OCTOBER 31, 1973

U.S. consul, retired, and former director of Nader's RPAG hearing disability study. (He is severely hard of hearing and legally blind.)

My comment on the Nader-sponsored Retired Professional Action Group (RPAG) report and the "footnote" about me in its "summary" of "Paying Through the Ear" is made here at the invitation of the Senate Special Committee on Aging in its letter of October 24, 1973.

The 400 word "footnote" (page 85) is more than a footnote and is unfortunate for all. It is too irrelevant, inaccurate, misleading, and unfair to warrant a detailed point-by-point response. As those concerned with deafness know and the footnote omits, I have devoted decades for the benefit of the hearing impaired. Therefore, it is enough to say that my resignation as an unpaid worker from the Nader group was not "by mutual agreement" as stated. I resigned because I disagreed with the group's philosophy and approach in the study. Further, 6 hours

after I left in early February 1973, before completion of the study, the group coordinator called and asked me to return. I declined. The RPAG statement that I "disagreed that all hearing impaired older people should receive benefits from Medicare to alleviate physical and financial difficulties which resulted from their hearing loss" is also inaccurate. I have always advocated such benefits, i.e., provision of hearing aids for all Medicare recipients who are clearly qualified for such assistance; and with distribution thru qualified dealers as in the vocational rehabilitation system.

My personal, independent judgment regarding the hard of hearing, hearing aids, Medicare and services, together with my credentials, is expressed in my letter to Senator Church of September 14, 1973 (page 101). Though I had previously heard and studied the Nader group's Senate testimony which was based on its report about to be released, I made no mention of the group's statements or its report in my letter.

As to the complete report, of which advance copies were distributed to the press prior to September 30, only one reporter questioned me on the subject and I responded very briefly to his questions.

Having read the report, I found the introductory statement to it quite revealing. It reads in part as follows: "The report is not intended to discourage any person from seeking help." Considering the critical nature of the voluminous report that statement of caution is needed, indeed. I hope the report will not "discourage" too many elderly hard of hearing people, but I fear that it could inadvertently confuse, if not frighten them—partly because so very few pages (47) are devoted to "the consumer guide section," which is at the end of the lengthy document (300 pages). And, in the RPAG "summary" of its report, submitted in October to the Senate committee,* there is no summary at all of the "consumer guide" portion for the hard of hearing.

As a retired international economist, I believe that "an exhaustive investigation" in any field can only benefit consumers if it is truly exhaustive, objective, balanced, and unbiased in all sectors covered. Unfortunately, that does not appear to be the case in this instance. The project coordinators of the Retired Professional Action Group are young, salaried, full-time, hard-working employees, but with virtually no actual experience in this subject area prior to the investigation.

My sole interest, as always, is in the needs of the hearing handicapped and, of course, I have never been affiliated with the hearing aid industry. In fact, during the last 12 months, before and after I resigned from RPAG, I gave a number of talks to trade and other groups in which I criticized hearing aid people and professionals for certain things. But I also gave them credit where credit was due. No business or profession, unless illegal, is generally, or even largely, as bad as some consumer advocates would have us believe, although all can be improved.

Theodore Roosevelt once said, when some of us were children: "Those with the muck-rake are often indispensable to the well-being of society, but only if they know when to stop raking the muck." To that I would add—and also reveal with equal vigor, what is clean and good to provide proper perspective and fairness.

JOSEPH E. WIEDENMAYER.

*See appendix 1, item 2, p. 84.

Appendix 2

ADDITIONAL MATERIAL FROM OTHER WITNESSES

ITEM 1. PREPARED STATEMENT OF DR. KENNETH O. JOHNSON,* EXECUTIVE SECRETARY, AMERICAN SPEECH AND HEARING ASSOCIATION

At the outset, the American Speech and Hearing Association (ASHA) wants to express, on behalf of its more than 16,300 members and the many thousands of communicatively handicapped Americans they serve, its profound gratitude to the Retired Professional Action Group (RPAG) for having so graphically pointed up the plight of hearing impaired older Americans. We are also appreciative of the subcommittee's providing this platform, so that the RPAG and other organizations and individuals concerned about an important aspect of the health and welfare of many of America's elderly can attempt once again to focus national attention on a health care sore spot that has persisted unattended for too long.

This subcommittee has previously heard delineated the issues which still contribute to our inability to assure reasonably priced quality rehabilitation services to the elderly hearing impaired[1]—issues which have concerned the Congress for at least a decade.[2] But never before have these issues been so thoroughly and tirelessly researched, so well documented, so clearly drawn. And never before has the voice of the hearing handicapped elderly consumer been heard quite so strongly as it is being heard now through the agency of such consumer interest spokesmen as the RPAG, the Minnesota Public Interest Research Group,[3] and public interest journalists in such large metropolitan areas as Minneapolis-St. Paul, Detroit, and Baltimore.[4]

Had consumer influence been brought to bear earlier on the problems discussed here today, perhaps legislative committees of the Congress would have been moved to follow up with meaningful legislative proposals the impressive initiative this special congressional panel took in July of 1968; perhaps, too, the pro-consumer recommendations of the 1962 Kefauver subcommittee (on antitrust and monopoly, Senate Judiciary Committee) would not have been transformed from what then seemed a consumers' shield into a sword wielded against America's hard-of-hearing public.[5]

The critical central issue of these and the earlier congressional hearings has not changed. It is our fervent hope, however, that congressional regard for that central issue will change in the direction of meaningful, creative legislation, as a consequence of the new ingredient of consumer outrage at the marketplace treatment of the hearing impaired older Americans.

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*See statement, p. 27.

[1] "Hearing Loss, Hearing Aids, and the Elderly." Hearings before the Subcommittee on Consumer Interests of the Elderly of the Special Committee on Aging, U.S. Senate, 90th Cong., 2d Sess., July 18 and 19, 1968.

[2] "Prices of Hearing Aids." Senate report No. 2216, 87th Cong., 2d sess., October 1, 1962.

[3] "MPIRG Report," Hearing Aids and the Hearing Aid Industry in Minnesota, November 13, 1972.

[4] See, e.g., Minneapolis Star, November 13, 14, 1972; Minneapolis Tribune, November 14, 1972; Detroit Free Press, February 25, 26, 1973; Baltimore Sun, May 13, 1973.

[5] A major Kefauver panel recommendation was for establishment of hearing-aid dealer licensing requirements by States as a means of controlling untoward dealer sales practices. According to a recent issue of the Hearing Aid Journal, the industry's monthly news magazine, "a veritable avalanche of opposition" to the concept came from industry members. In the meantime, however, the primary focus of State dealer-licensure legislation has changed from consumer protection to industry protection. "Most of the dealers operating in the 14 unlicensed States are now clamoring for the passage of a good protective licensing act." (Milton Bolstein, "Licensing . . . And How It Has Changed," Hearing Aid Journal, July 1973, p. 3.) One industry spokesman goes so far as to label licensing for hearing aid dealers as "the key to . . . survival." (W. Hugh Conaughty, "The Licensing Effort Never Ends," ibid., p. 5.)

The critical issue which obviously pervades these hearings and the reports of those conducted in 1968 and 1962 is that the hearing aid delivery system in the United States represents and fosters a clear and continuing conflict of hearing aid industry interest of significant proportions.

The economies of the industry and its retail practitioners depend exclusively on sales volume—the more sales made, the more fiscally successful the retailer, the greater the industry's profits. ASHA is assuredly not opposed to profit or to the full and fair operation of the free enterprise system. But it does have profound reservations about any system which pits the financial interest of a seller against the health and economic interests of a buyer and then permits the seller the choice of alternatives. Our reservations in this regard are heightened by the fact that unless hearing aid dealers qualify as audiologists or physicians specializing in diseases of the ear, they are simply unable to satisfactorily evaluate the integrity of the auditory (hearing) system, to locate the anatomical location of an auditory problem, or to assume responsibility for the rehabilitation of the hearing impaired. The percentage of dealers so qualified is so infinitesimal as to defy calculation.

The solution to this conflict of interest situation is as obvious today as it was when last this subcommittee held hearings on hearing aids and the elderly, or when the Kefauver subcommittee earlier undertook its inquiry into the pricing practices of the hearing aid industry. If this and earlier congressional efforts as well as recent consumer group initiatives are to mean more to the elderly hearing impaired than ineffectual gestures, however well intended, hearing aid salesmen must be precluded by law and appropriate administrative regulations from selling a hearing aid without first obtaining an order, written by a physician specializing in diseases of the ear or by an audiologist, to provide a specific aid to a specific customer whose hearing has been evaluated by the prescribing professional. Unless such regulation at national and State levels occurs, we shall continue to have a situation in which untrained nonprofessional personnel diagnose complex health problems, prescribe prosthetic devices, and accept payment for providing a device which the seller cannot assure is appropriate to the buyer's health need or needed at all. Unless the subcommittee calls for such regulation in its final report on these hearings, we believe it will have failed to meet effectively the objective it set for itself more than 5 years ago: i.e., ". . . to help older Americans—those most vulnerable to deafness and near deafness—to save themselves from the isolation, demoralization, and hazards that occur when hearing deterioration becomes severe." [6]

For decades, the sale of eyeglasses to the visually handicapped has been possible, under law, only after prior examination and prescription by a physician specializing in diseases of the eye or an optometrist. ASHA believes that the hearing handicapped people of this country should be accorded equal protection of law; that they, too, should be assured the expert advice of an appropriately qualified health professional prior to their purchase of a health appliance. In the instance of the hearing handicapped, the appropriately qualified health professional is a physician specializing in diseases of the ear or an audiologist.

ASHA is a national scientific and professional society of speech pathology and audiology practitioners, 2,103 of whom, as of July 1 of this year, have been certified as clinically competent in the area of audiology.[7] Five hundred and fifty-four additional individuals were on the continuum of professional preparation at midyear, having fulfilled their master's degree requirement and in the process of accumulating the supervised clinical work experience required for certification.[8]

The ASHA certification of clinical competence in audiology represents that its holder has earned a master's degree in audiology from a graduate training program which meets course content and supervised clinical work criteria established by ASHA; completed the equivalent of 9 months of full time, supervised experience in the practice of audiology; and passed the national examination in audiology, which is administered by the Educational Testing Service, Princeton, N.J.[9] Government health and education programs universally define "audiologist" as the possessor of the ASHA certificate of clinical competence in audiology (or

[6] Hearings before the Subcommittee on Consumer Interests of the Elderly, op. cit., p. 1.
[7] Edward Bruder, "Official ASHA Counts: July 1, 1973" (unpublished report), August 13, 1973, p. 7.
[8] Ibid.
[9] A full delineation of the requirements for the certificate of clinical competence in audiology appears as addendum I, infra (retained in committee files).

its equivalent, in terms of appropriate education and experience).[10] Audiologists regarded by the U.S. Social Security Commission as "qualified" to render audiology services to Federal health program beneficiaries include both those fully certified (i.e., the 2,103 figure, supra.) and those who have met the education requirement for ASHA certification and are in the process of fulfilling the supervised clinical experience requirement (i.e., the 554 figure, supra.).[11] The total number of audiologists qualified to render Medicare covered diagnostic audiological services to hearing impaired Americans age 65 and older, then, as of July 1 of this year, is 2,657.

We offer these figures in an effort to point up as graphically as possible the fallacy which attaches to the premise proffered in some quarters that there are insufficient numbers of audiologists in the country to adequately meet the rehabilitation needs of America's elderly hearing impaired. Based on that premise are assertions that a written audiologist's prescription should not be made a prerequisite for the purchase of a hearing aid—even in the event that the Medicare system begins to assume hearing aid costs now being paid by hearing handicapped older Americans.

A calculation involving the number of Americans 65 years of age and older (20.8 million)[12] and the prevalence of significant hearing impairments in that group (20 of every 100),[13] indicates that about 3,000 full time equivalent audiologists are needed to provide appropriate hearing aid related services to every elderly American with a bilateral hearing loss significant enough to affect his ability to hear and understand speech.[14] To add to this calculation the facts that there are 5,500 to 6,000 physicians in this country who specialize in diseases of the ear,[15] that the current number of ASHA-certified audiologists is expected to more than double in 5 years,[16] and that clinical programs offering qualified audiology services are widely available throughout the country[17] . . . to add these elements to our calculation is to knock into a cocked hat any and all assertions that there are too few genuinely qualified professionals in the hearing health field to permit the introduction of a legal prescription requirement into the existing hearing aid delivery system.

It is ASHA's major recommendation to this subcommittee that your report on these hearings call upon appropriate legislative committees of the Congress and upon State legislatures across the country to enact statutes establishing just such a prescription requirement.

It is our further hope that the following ASHA recommendations will be echoed in the subcommittee's final report:

(1) That the Senate Finance Committee and House Ways and Means Committee begin work on legislation designed to provide Medicare reimbursement to hearing impaired elderly Americans who purchase hearing aids on the written order of a physician specializing in diseases of the ear or an audiologist. ASHA has previously outlined its belief that an economically manageable, as well as humanitarian, Medicare hearing aid program could be established by reducing the cost of aids through the development of a national hearing aid purchasing program, and by carefully determining the hearing loss level at which eligibility for an aid would attach.[18] Hearing aid related services performed by the physi-

[10] See, e.g., 38 F.R. 18978 (July 16, 1973, effective July 13, 1973); Occupational Outlook Handbook in Brief, U.S. Department of Labor, Bureau of Labor Statistics (spring 1972), p. 6; announcement WA–7–27: Professional Careers in Audiology and Speech Pathology, Interagency Board of U.S. Civil Service Examiners (August 22, 1967): Dictionary of Occupational Titles (vol. I), U.S. Department of Labor, Bureau of Employment Security (1965), p. 30; and see 38 F.R. 18623 (July 12, 1973).

[11] See, e.g., 38 F.R. 18623, 18978, ibid.

[12] Source: United States Bureau of the Census: 1972.

[13] Source: National Center for Health Statistics: Vital and Health Statistics, series 10, No. 79.

[14] "Determination of Manpower Needs in Speech Pathology-Audiology" (unpublished report), American Speech and Hearing Association (July 26, 1973), p. 4. In addition to several realistic, even conservative assumptions related to such of its elements as the number per-client hours involved in meeting primary hearing-rehabilitation needs, the calculation assumes that the audiologsts involved devote their total professional effort to meeting the hearing-rehabilitation needs of persons 65 and older.

[15] Source: Unpublished data based on 1973 survey of members of the American Council on Otolaryngology.

[16] Source: Unpublished data based on 1973 survey of members of the American Speech and Hearing Association.

[17] See, A Guide to Clinical Service Programs in Speech Pathology and Audiology 1973 (Washington, D.C.: American Speech and Hearing Association), 1973, which appears as addendum 11, infra (retained in committee files).

[18] Hearings before the Subcommittee on Consumer Interests of the Elderly, op. ct, p. 148.

cian or audiologist should be considered Medicare reimbursable under any such program.

(2) That State legislatures begin consideration of proposals aimed at outlawing door-to-door and mail order hearing aid sales, and forbidding all other hearing aid sales not preceded by written authorization on the part of a physician specializing in diseases of the ear or an audiologist.

(3) That appropriate Federal agencies undertake to support meaningful continuing education and training programs for practitioners in health professions and health related occupations involved to a significant degree in the hearing aid delivery system; similarly, that appropriate agencies begin to support a public education program which can effectively meet the great public need to know such things as what is available in the hearing health field and where is it available. ASHA agrees generally with the thrust of the RPAG recommendations which call for expanded efforts and increased expenditures by all segments of the hearing aid delivery system in the practitioner training and public education areas. But these individual segments have made independent efforts in these directions before, with frequent dissonance and occasional confusion for the hearing impaired consumer. What is needed, we believe, is a single, strong, credible, well funded, federally guided program which has practitioner training and public information/education components. We would think that the Office of Human Development (Office of the Secretary, DHEW) and the Medical Services Administration (DHEW) would be appropriate for helping the respective segments of the hearing aid delivery system join in the creation and conduct of such a program.

(4) That the Senate Subcommittee on the Handicapped and the House Select Education Subcommittee approve Rehabilitation Act related legislation affording protection of the law to hearing handicapped Americans which equals that which the act affords the visually impaired. Rehabilitation Act funds cannot be utilized to help purchase eyeglasses unless the eyeglasses are first prescribed by a physician specializing in diseases of the eye or an optometrist. While act authorized funds can be utilized to help purchase hearing aids, however, there is no requirement mandating prior prescription by a physician specializing in diseases of the ear or an audiologist.

(5) That the Senate and House Committees on the District of Columbia (fortunately, the chairman of the Senate panel, Senator Eagleton, is a member of this subcommittee) develop legislation mandating appropriate hearing aid prescription prior to purchase in the District, and, in appropriate licensure proposals, develop realistic operational parameters for audiologists and hearing aid dealers practicing in the District.

ITEM 2. LETTER FROM RICHARD J. DOWLING,* AMERICAN SPEECH AND HEARING ASSOCIATION, TO WILLIAM E. ORIOL, STAFF DIRECTOR, COMMITTEE ON AGING, DATED AUGUST 30, 1973

DEAR MR. ORIOL: This letter concerns an issue related to the committee's upcoming hearings on hearing aids and the elderly.

Several years ago, the Trademark Division of the U.S. Patent Office granted a trademark to the National Hearing Aid Society for use by members of that Michigan based organization who, upon successful completion of an unsupervised, mail order course of instruction and a similarly unsupervised, mail order examination, are granted the title "certified hearing aid audiologist." The phrase "certified hearing aid audiologist" is a prominent part of the trademark.

Today, there are about 1,900 certified hearing aid audiologists nationwide—in the District and all but one of the States (Alaska). Their trademarked title is widely advertised.

There are about 2,200 audiologists in the United States—hearing rehabilitation professionals who have obtained at least a master's degree or its equivalent in audiology, undergone a year of supervised clinical experience, and passed a national examination in audiology administered by the Educational Testing Service, Princeton, N.J., to achieve certification by their professional association. Like other health professionals, audiologists may not advertise their services.

*See statement of association, p. 27.

Law prohibits the sale of eyeglasses without a prescription from a physician specializing in diseases of the eye or an optometrist. Obtaining a prescription from a physician specializing in diseases of the ear or an audiologist is not prerequisite to the purchase of a hearing aid.

It should not be surprising, then—what with the aura of "professionalism" which the trademark bestows upon hearing aid salesmen, plus the lack of a prescription requirement—that close to 80 percent of America's hearing aid users have purchased their aids, usually at great expense, without first determining (1) whether, in fact, an aid is needed (the hearing problem may require surgery or, in the alternative, the simple removal of wax); (2) whether rehabilitation procedures (e.g., lipreading training), other than or in addition to the use of an aid, are appropriate; or (3) which hearing aid brand and model is most appropriate for a particular hearing problem. Qualified hearing health professionals can make these determinations; salesmen, in the overwhelming majority of cases, cannot.

Interesting footnotes to the professional posturing which the trademark permits hearing aid salesmen are the facts that numerous Federal and State statutes and regulations define "audiologist" as it is defined above (i.e., the master's degree plus; see, e.g., 38 Federal Register 18623 and 38 FR 18979), and that obviously unenforced laws of more than a dozen States specifically prohibit use of the word "audiologist" by hearing aid salesmen.

The trademark and the promotional uses to which it has been put clearly serve to mislead the hearing handicapped public. We believe that the Trademark Division of the U.S. Patent Office, by encouraging, albeit unwittingly, the inappropriate utilization of the term "audiologist," must share the responsibility for this result.

It is our hope that some action can be taken—short of protracted and costly legal action—to correct the Trademark Division's oversight. We would appreciate the committee's calling upon Patent Office officials for suggestions regarding what that agency might do in this respect on behalf of the elderly hearing handicapped.

Sincerely,

RICHARD J. DOWLING,
Director of Governmental Affairs.

ITEM 3. LETTER FROM RICHARD J. DOWLING,* AMERICAN SPEECH AND HEARING ASSOCIATION, TO WILLIAM E. ORIOL, STAFF DIRECTOR, COMMITTEE ON AGING, DATED SEPTEMBER 12, 1973

DEAR MR. ORIOL: This letter is in response to a request you addressed to spokesmen for this association during a September 10 appearance before the Special Committee's Subcommittee on Consumer Interests of the Elderly. The request concerned backup for the projection, contained in the written statement* which ASHA submitted to the subcommittee, that the current number of ASHA certified audiologists (2,657 as of July 1, 1973) would more than double in 5 years.

Since 1958, ASHA has systematically monitored the numbers of undergraduate, master's and doctoral degrees awarded in speech pathology and audiology. Utilizing these data, Analysis and Programming Corp. (1747 Pennsylvania Avenue N.W., Washington, D.C. 20006) has developed a regression equation which yields a linear projection of speech pathology and audiology graduates in future years. (In view of the accelerated growth rate of speech pathology and audiology graduates in recent years, it should be noted, the projection represents a conservative growth estimate.) This technique predicts that by June of 1978, 17,005 graduate degrees in speech pathology and audiology will have been awarded. Current ASHA certification records indicate that 18 percent of all new members are audiologists. Thus, by mid-1978, some 3,061 graduate audiologists will have entered the work force.

Further evidence of the conservative nature of this projection is available in the results of a speech pathology-audiology manpower survey conducted during

*See statement of association, p. 27.

the 1972–1973 academic year—at which time about 32,000 speech pathology-audiology students were undergraduates, 7,900 were candidates for master's degrees, and 1,150 were doctoral candidates. Audiology was the declared professional specialty of 17 percent of the masters' and 25 percent of the doctoral students. Assuming 55 percent of the current undergraduates complete master's or doctoral degree programs (as is the pattern in the past), it may be said that there are over 4,600 students currently enrolled in college and university training programs who intend to enter the audiology work force upon graduation.

Thank you for the opportunity to present these additional views. I would hope they will be included in the formal record of the subcommittee's September 10 and 11 proceedings.

Sincerely,

RICHARD J. DOWLING,
Director of Governmental Affairs.

ITEM 4. LETTER AND ENCLOSURE FROM KENNETH O. JOHNSON,* AMERICAN SPEECH AND HEARING ASSOCIATION, TO SENATOR FRANK CHURCH, DATED SEPTEMBER 26, 1973

DEAR SENATOR CHURCH: Thank you for your letter of September 15, 1973. I hope the following comments will help to clarify some of the issues and questions raised during your Committee's hearings on September 10 and 11.

The preparation of audiologists in the area of hearing aids has been an integral part of their education and training since the inception of the field in the mid-1940's. Some of the major functions of the military aural rehabilitation programs established during World War II were to determine hearing aid candidacy, to select an appropriate wearable aid, and to provide orientation in the use of a hearing aid. The profession of audiology evolved from these military programs. A significant portion of the clinical and research literature of audiology pertains to hearing aids. Interestingly, many of the technical articles appearing in the trade magazines of the hearing aid industry are written by audiologists. In 1952, ASHA approved "Minimum Requirements for Hearing Programs Offering Guidance in Selection of Hearing Aids" (exhibit 1). Moreover, the annual facts and figures of the hearing aid industry reveals that audiologists are progressively becoming more involved in selecting hearing aids. In 1958, only about 8 percent of hearing aid sales were based on referrals from audiologists whereas in 1972 these referrals increased to 14.5 percent.

The audiologist's preparation to determine hearing aid candidacy, select appropriate amplification, and provide other rehabilitative services is recognized by many agencies, consumers, and existing statutes. You have heard considerable testimony that hearing aids are both selected and dispensed by audiologists in the VA system. However, most, if not all, State crippled childrens services require a recommendation by an audiologist for a hearing aid prior to authorizing purchase of an aid for a child. The Social and Rehabilitation Services (HEW) reports that approximately 50 percent of hearing aids purchased by State Vocational Rehabilitation programs are upon recommendation by audiologists. Some State licensure acts for hearing aid dealers include an age restriction clause which prohibits dealers selling aids to children without prior recommendation by an audiologist and medical clearance by an otolaryngologist. Other States require only a recommendation by an audiologist or otolaryngologist. Minnesota recently promulgated a registration act which requires that hearing aid dealers obtain a recommendation from an audiologist or a physician before they sell a hearing aid to an elderly person or to a child.

During the hearing you raised a question concerning the availability of professional services in the rural areas of Idaho. The provision of professional services to persons in rural areas has always been and may continue to be a major problem in the delivery of any health service. One alternative is to decide against providing professional services to anyone because society is unable presently to provide such services to 100 percent of the population? A seemingly better alternative would be to make exceptions in areas where professional services are unavailable and people are unable to travel. Audiological services should be used whenever they are available. For example, Mildred Shapiro** testified that in

*See statement of association, p. 27.
**See Hearing Aids and the Older American, part 2, p. 225.

New York State, Medicaid usually requires that in counties where hearing and speech centers are available, audiological services will be utilized for the evaluation of hearing and the selection of a specific aid.

Thank you for providing the American Speech and Hearing Association an opportunity to testify before your Subcommittee on Consumer Interests of the Elderly and the subsequent opportunity to present additional comments for inclusion in the record. Please contact us if we can be of further service.

Respectfully submitted,

KENNETH O. JOHNSON, Ph. D.,
Executive Secretary.

Enclosure.

MINIMUM REQUIREMENTS FOR HEARING PROGRAMS OFFERING GUIDANCE IN SELECTION OF HEARING AIDS*

The American Speech and Hearing Association recognizes that the activities of a hearing service are diverse. No single definition can cover all of the legitimate activities that such programs incorporate. In general, such programs offer education and rehabilitation services but do not engage in the sale or maintenance of hearing aids. However, the assessment of hearing to evaluate the potentialities which individuals have for use of hearing aids is frequently an important phase of a program's activity.

A hearing center may be associated with an education institution, a hospital, or a service agency. There is no inherent reason why such a center could not be a private venture provided its practices and ethics conform to recognized professional standards. The center may offer medical services if appropriately affiliated and staffed. In any event, the services of the center are distinguished from the general practice of otolaryngology because of their emphasis on non-medical rehabilitation. Conversely, its services are distinguished from schools whose purpose is the long term academic training of pupils with auditory impairments.

The American Speech and Hearing Association is committed to the philosophy that every activity worthy of designation as a hearing program should satisfy realistic standards insuring its competence. Generally speaking, there is a widely recognized frame of reference for such standards. The qualifications which a center's personnel may be expected to satisfy are implicit in (1) the degree requirements of institutions offering training in audiology, (2) the requirements of the several states for certification of teachers, and (3) the Association's own requirements for clinical competence in the field of hearing. In turn, competent personnel will make demands on administrative superiors which will encourage adequate physical facilities and equipment for the center. Thus, there does not at the moment seem to be need to formulate requirements covering all phases of a hearing program's activities. The principles already established by current practices and a general program of assuring recognition of competent professional workers appear ample safeguards.

The situation is somewhat different when one of the services offered is guidance in selection of hearing aids. This consideration leads to the following statement of requirements which the American Speech and Hearing Association deems minimal if a center engages in this activity.

MINIMUM REQUIREMENTS

A hearing program shall be considered as equipped to engage adequately in the task of guidance in the selection of hearing aids only if it satisfies all the criteria listed below.

I.A. The center shall follow a sound plan for obtaining otological guidance and advice regarding its policies and practices.

B. The center shall follow a sound policy of obtaining otological diagnoses and adhering to medical recommendations.

C. Except where there is medical approval to the contrary, final recommendations regarding hearing aids will be withheld until medical or surgical regimes advised by the otolaryngologist shall be completed.

*These requirements were recommended by the Committee on Minimum Requirements for Hearing Clinics (Jack L. Bangs, George A. Falconer, Wallace A. Goates, John W. Keys, Donald M. Markle, S. Richard Silverman, Jesse J. Villarreal, Raymond T. Carhart, chairman) and approved by the executive council at the 1952 annual convention. Revised November 1964.

D. If appropriate medical clearance is obtained, the center may make ear impressions and may arrange for the manufacture of earpieces as an adjunct to proper testing.

II.A. The individual supervising the program of hearing aid selection and the persons conducting the tests and other routine activities of the program for hearing aid selection should satisfy the qualifications for the Certificate of Clinical Competence in Audiology.

B. A person who does not satisfy the above criteria may be used only if three conditions are met.*

1. His activities shall be directly supervised by a certified member of the center's staff.

2. The evaluation of findings and the clinical decisions arising therefrom shall remain the responsibility of the staff member.

3. He shall have had sufficient instruction, both theoretical and practical, to qualify him for participation in the program before undertaking the above duties.

III.A. Special testing rooms shall be so constructed and located as to supply a physical environment which is acceptable for the use to which they are put. The basic requirement is that all special facilities must make possible the validity of the tests or other techniques conducted therein.

B. The electro-acoustic and other equipment employed in testing patients shall satisfy the conventional standards for adequacy. The equipment shall be used in such manner as to maintain the validity of the tests employed. This requirement includes arrangements to keep the equipment properly calibrated and in good working condition.

Current practice indicates that ordinarily the minimum equipment is that which allows the exploration of threshold for pure tones as well as both threshold and supra-threshold hearing for speech. Procedures may change as a result of advancing knowledge, and it is explicitly intended that the equipment shall be consistent with contemporary clinical standards.

IV. The hearing program shall have ample and satisfactory provisions for the educational and rehabilitational management of the persons examined. Either the center must offer these facilities itself, or a sound plan of referring cases for these services must be in effect.

V. Any stock of commercial hearing aids with which cases are tested shall represent a reasonable sample of the hearing aid characteristics which are currently available. Furthermore, provisions shall be made to keep these hearing aids in proper working condition.

VI. The center shall not engage in the sale of hearing aids or accessories.

VII. The center shall adhere to sound ethical practices.

A. The Code of Ethics of the American Speech and Hearing Association shall be observed.

B. The center shall maintain a positive policy of offering access to its philosophy and method of operation.

C. The center shall not release advance information on its recommendations to a commercial organization or an individual engaged in the sale of hearing aids.

VIII. The center shall adhere to a policy of referring patients about to purchase hearing aids only to commercial organizations and individuals who have demonstrated their integrity, their competence in dealing with hard-of-hearing persons, and the adequacy of both their facilities and service.

ITEM 5. LETTER AND ENCLOSURES FROM RICHARD J. DOWLING,** AMERICAN SPEECH AND HEARING ASSOCIATION, TO SENATOR FRANK CHURCH, DATED SEPTEMBER 26, 1973

DEAR SENATOR CHURCH: Pursuant to your September 10 request for more detailed information on the graduate training of audiologists, I am forwarding three exhibits for your and the committee's perusal: (1) A summary description of the American Boards of Examiners in Speech Pathology and Audiology (ABESPA) (one of which, the education and training board, as of September 15,

*It is the sense of this requirement that students-in-training shall not be substituted for qualified personnel. Students-in-training are here defined as individuals engaged in mastering the techniques involved in hearing aid selection.

**See statement of association, p. 27.

1973, has recommended the accreditation of 85 master's degree speech and hearing training programs); (2) A summary of the requirements established by the education and training board for the accreditation of graduate training programs in speech pathology and audiology; and, (3) excerpts from an application for accreditation submitted to the education and training board by one of the 85 accredited graduate training programs.*

The education and training board accreditation program of ABESPA is recognized by the U.S. Commissioner of Education and the National Commission on Accrediting as the national organization responsible for accrediting graduate education programs in speech pathology and audiology.

We would hope that this letter and its three attachments will be included in the published record of those deliberations.

Sincerely,

RICHARD J. DOWLING,
Director of Governmental Affairs.

Enclosures.

Exhibit 1

THE AMERICAN BOARDS OF EXAMINERS IN SPEECH PATHOLOGY AND AUDIOLOGY, AMERICAN SPEECH AND HEARING ASSOCIATION. RICHARD M. FLOWER, PH. D., CHAIRMAN, WASHINGTON, D.C.

The American Boards of Examiners in Speech Pathology and Audiology of the American Speech and Hearing Association was established in 1959 to formulate standards and procedures for the determination of qualifications of individuals, organizations and institutions applying for Certificates of Accreditation or Clinical Competence; to establish, maintain and monitor Boards of Examiners responsible for arranging and conducting examinations to determine the qualifications of applicants for such certificates; to grant and to issue appropriate certificates; to maintain a registry of holders of such certificates; to prepare and to furnish to proper persons and agencies, lists of individuals, organizations, and institutions who have been issued such certificates.

The three boards of the American Boards of Examiners in Speech Pathology and Audiology are: the Education and Training Board, to whom ABESPA has delegated the responsibility for receiving and evaluating applications for the accreditation of master's degree programs in speech pathology and/or audiology and recommending to ABESPA that such accreditation be granted or withheld; the Professional Services Board, to whom ABESPA has delegated the responsibility for receiving and evaluating applications for accreditation in speech pathology and/or audiology from clinical services programs and for recommending to ABESPA as to whether such accreditation should be granted or withheld; and, finally, the Clinical Certification Board, to whom ABESPA has delegated the responsibility for receiving and evaluating applications for the Certificate of Clinical Competence in Speech Pathology and/or Audiology submitted by individuals who wish to provide services to the communicatively handicapped. Applicants for such certificates must not only meet academic course work, clinical practicum, and professional experience criteria in order to achieve certification, they must also pass the National Examination in Speech Pathology and/or Audiology, prepared by the Clinical Certification Board for administration as an area examination of the National Teacher Examinations division of Educational Testing Service, Princeton, N.J. The American Speech and Hearing Association, through the American Boards of Examiners in Speech Pathology and Audiology, is recognized as the sole accrediting agency for master's degree programs in speech pathology and/or audiology by the National Commission on Accrediting and the Commissioner of the U.S. Office of Education. As of September 15, 1973, 85 master's degree programs have been accredited in speech pathology and/or audiology on the recommendation of the Education and Training Board; 575 clinical services programs have been accredited in speech pathology and/or audiology on the recommendation of the Professional Services Board and 11,919 Certificates of Clinical Competence in Speech Pathology and/or Audiology have been issued to individuals on the recommendation of the Clinical Certification Board.

*Retained in committee files.

Exhibit 2

ACCREDITATION OF PROFESSIONAL EDUCATION PROGRAMS IN SPEECH AND AUDIOLOGY; EDUCATION AND TRAINING BOARDS OF EXAMINERS IN SPEECH PATHOLOGY AND AUDIOLOGY

I. Accreditation in Speech Pathology and Audiology

ACCREDITING AGENCY

The American Speech and Hearing Association is the organization recognized by the National Commission on Accrediting and the Commissioner of the U.S. Office of Education to accredit master's degree programs devoted to professional training in speech pathology and audiology. The American Speech and Hearing Association is a national, voluntary, nonprofit organization composed of persons whose primary professional commitment is to disorders of human communication and to the scientific study of speech, hearing, and language. The association was founded in 1925. By 1972, its membership exceeded 14,000 persons. Its bylaws state that its purposes ". . . shall be to encourage basic scientific study of the processes of individual human speech and hearing, promote investigation of speech and hearing disorders, and foster improvement of therapeutic procedures with such disorders; to stimulate exchange of information among persons thus engaged, and to disseminate such information."

The association has established the American Boards of Examiners in Speech Pathology and Audiology as its agent for evaluating both training programs and organizations offering clinical services to the public. The Boards of Examiners have designated the Education and Training Board to carry out the work of accrediting training programs.

PURPOSES OF ACCREDITING

The interest of the American Speech and Hearing Association in accreditation is based on the belief that any professional field which provides services to the public has a social obligation to ensure, insofar as possible, that the services provided by its members are of high professional quality. One of the most effective ways that this obligation can be met is to establish appropriate standards of education and training for its incoming members and to identify those training institutions which maintain adequate standards in their education programs. The American Speech and Hearing Association has assigned this responsibility to the American Boards of Examiners in Speech Pathology and Audiology whose constituent board, the Education and Training Board, has been specifically established to carry on the accreditation functions of the association. The specific purposes of the accreditation program as administered by this board are as follows:

(1) To stimulate and foster constant improvement of professional education in speech pathology and audiology. To assist training institutions to develop programs of instruction of high quality by stimulating continuous self-study and improvement.

(2) To establish criteria for approval of education and training programs which will ensure that institutions meeting these criteria provide students with the opportunity to become sufficiently trained, both extensively and intensively, to enable them to identify the human problems that are their particular responsibility and to provide proper care and management for these problems.

(3) To establish criteria for approval which will ensure that students graduating from approved programs are not only professionally competent but also have the requisite knowledge and skills to keep abreast of new advances in the field.

(4) To publish periodically a roster of accredited programs so that the members of the profession, the public, Government agencies, and prospective students may have authoritative information.

DEVELOPMENT OF POLICIES

Development of policies and criteria for accreditation is the responsibility of the Education and Training Board, subject to review by the American Boards of Examiners in Speech Pathology and Audiology. Primarily for the purpose of assisting colleges and universities as they strive to improve their educational

programs in the speech and hearing field, the Education and Training Board prepared section II of this document, "Essentials of an Acceptable Program of Training for Speech Pathologists and Audiologists." The drafting of this section by the Education and Training Board was preceded by consultation with other organizations including the American Dental Association, the American Medical Association, the American Psychological Association, the Council on Social Work Education, and the National Commission for Accreditation of Teacher Education.

The continuing process of policy development is governed by the desire to establish guidelines and objectives for improving the quality of training programs, to develop criteria for evaluating educational offerings, to recognize those programs which meet minimum standards, and to offer guidance to those which do not.

ELIGIBILITY

The general criteria for eligibility for an evaluation by the Education and Training Board are as follows:

(1) The institution must be accredited by the appropriate regional accrediting association, if eligible.

(2) The institution must offer a master's degree in speech pathology, audiology, or both.

(3) The program in speech pathology and/or audiology must have been fully functioning for the 3 consecutive years prior to application. Also, the program must have graduated a minimum of six students, at the master's level, in the area for which accreditation is sought, within the three-year period prior to submitting application for accreditation.

(4) The institution must provide evidence of adequate administrative organization and support to ensure the stability of the program and the maintenance of adequate standards.

APPLICATION FOR EVALUATION

Application for evaluation is made to the chairman of the Education and Training Board. Submission of an application is voluntary, and an application may be withdrawn at any time prior to final action by the American Boards of Examiners in Speech Pathology and Audiology. Application may be made for simultaneous evaluation of both areas (speech pathology and audiology). Each area must meet the requirements independently.

PROCEDURE FOR APPLYING

Complete evaluation of a program includes a site visit to the institution. Five steps precede the site visit:

(1) Upon request, the chairman of the Education and Training Board will send the manual entitled "Accreditation of Professional Education Programs in Speech Pathology and Audiology."

(2) The institution submits a formal application for evaluation, signed by the president of the institution or his authorized representative. The application is accompanied by the written information specified in section III, "Outline of Information," to be submited by the institution.

(3) The program must furnish a statement indicating its compliance with the Civil Rights Act and should conduct recruiting, and evaluation procedures in a manner which will ensure equitable treatment of students without regard to sex, race, age, creed, or national origin, and should encourage the recruitment and participation of minority students and faculty.

(4) The Education and Training Board (ETB) evaluates the materials received from the applicant institution for completeness and adequacy. If obvious deficiencies are noted, they will be reported to the institution. Written applications which are complete and in proper order are given a preliminary review for the following purposes:

(a) To determine whether a site visit is to be scheduled without delay.

(b) To determine features of the program that should be given particular attention by the site visitors.

(5) If the preliminary review raises any serious question concerning the capability of a program to be accredited, the board may recommend that the site visit be delayed until such time as the apparent deficiencies are corrected. In such an event, the chairman notifies the institution of this recommendation and

the reasons for it. The institution is also advised that, if it believes the board's preliminary evaluation to be in error, it can (1) submit further information to clarify the matters in question, or (2) request that a site visit be conducted despite the Board's recommendation for deferral.

An application will be considered to be "in process" under the following circumstances:

(1) The application has been sent to ETB for review.

(2) The application shall remain "in process" as long as the procedure for approval or disapproval is in operation or until the institution is notified otherwise by ETB.

The institution will be notified by the chairman of ETB when the board rules that an institution's circumstances no longer warrant the status of "in process." It is reasonably clear that the "in process" status ceases (without notification from the board) when (1) the application for accreditation has been voluntarily withdrawn by the institution, or (2) accreditation has been withheld.

It is the intent of the board to interpret the term "in process" as liberally as possible to encourage institutions to become accredited.

The following limits are placed upon delays in the institution fulfilling its responsibilities:

(1) If ETB requests additional information from the institution before a site visit will be approved, a reminder will be sent at the end of 6 weeks if there has been no reply. After an additiional 6 weeks, a letter will be sent stating that it is assumed that the application has been withdrawn. When an institution reapplies under these circumstances, no additional fee is necessary.

(2) After a site visit has been approved, the date for the visit will be arranged within a 3-month period unless these are extenuating circumstances.

(3) If the institution has not responded to the digest of the site visit in 2 months, followup letters will be sent. If a response has not been received in one month after the followup letters have been sent, the application is considered withdrawn.

VISITING TEAM

Each site visit team consists of at least two members. They are responsible for gathering information, observing, and describing the program of professional education in speech pathology and audiology offered by the applicant institution. These persons may be part of a larger group if their visit is coordinated with concurrent evaluations in other academic or professional areas. The personnel of the visit team are chosen according to the following rules:

(1) The chairman of the Education and Training Board selects the site visitors from a roster which has been developed by the Education and Training Board and approved by the American Boards of Examiners in Speech Pathology and Audiology. No individual residing in the same state as the applicant institution will be selected as a site visitor.

(2) The chairman reports his selections to the applicant institution before notifying the prospective site visitors, so that the institution may inform the chairman if it has reason to request a change in the roster of visitors.

(3) The Chairman of the Education and Training Board designates a member of the team as chairman of the site visit.

THE VISIT

When possible, the site visit will be coordinated with the activities of the regional accrediting agency in an appropriate fashion. A typical visit consists of a 2- or 3-day review of the program. The chairman of the site visit team outlines in advance for the director of the program being reviewed the types of activity which the visit is to include. In general, the team plans to:

(1) View major physical facilities;

(2) Review the program with the academic and clinical staff;

(3) Confer with administrative officers, including officials who can discuss with authority the institution's overall attitudes toward, and plans for, the program in speech pathology and audiology. An interview with the president or his designee will be requested for the site visitors;

(4) Confer with individual staff and faculty members;

(5) Interview students at several academic levels;

(6) Interview graduates, if practical; and

(7) Review such materials as records of speech and hearing cases, summaries of student programs, etc.

The director of the program then arranges the schedule for the visit to suit local conditions. However, he is instructed to leave the evenings unscheduled so that the site visitors can use this time to discuss what they have seen and to prepare for the next day.

Whenever possible, the members of the team will confer, for the purpose of verifying their information, not only with the director of the program but also with other administrative officials.

THE TEAM REPORT

The chairman of the site visit team prepares a written report which the team submits to the Education and Training Board. This report will include statements regarding:

(1) The strengths of the program;

(2) The weaknesses of the program;

(3) Any factors of importance which are not included in the materials previously supplied by the applicant institution;

(4) Suggestions which can be of assistance to the director of the program under consideration; and

(5) Statement of recommendations.

A digest of the report or statement of strengths and weaknesses (with omission of the team's recommendations) will be sent to the director of the program and to the president of the institution or his designee, for verification of the factual data and for comment on the impressions of the site visitors.

ACTION ON THE REPORT

The Education and Training Board reviews the materials submitted by the institution, the report of the visiting team, and any comments from the administrative officers of the applicant institution. A member of the board prepares a report which presents the board's recommendations and summarizes the information supporting these recommendations.

The chairman of the Education and Training Board submits the report to the American Boards of Examiners in Speech Pathology and Audiology, which then takes whatever action it deems appropriate. Action may be approval of the speech pathology program, the audiology program, or both, or approval may be withheld.

The American Boards of Examiners in Speech Pathology and Audiology transmits a written report of its action to the applicant institution. The director of the program is urged not to seek interpretation of the report from individual members of the board or the site visitors.

PROBATIONARY STATUS AND REVOCATION OF ACCREDITATION

After the receipt of (1) an unsatisfactory annual report; or (2) evidence of violation of agreed upon ethical standards; or (3) a significant lapse of standards on which accreditation was granted, the program will be reviewed by ETB and appropriate hearings and/or site visits will be arranged. If the results are unsatisfactory, the accreditation may be withdrawn or the institution may be placed on probationary status for 1 year during which corrective action must be taken. After the probationary period, a second review will take place, the findings of which will determine whether full accreditation will be restored or whether accreditation shall be withdrawn.

In order to be reinstated after accreditation has been withdrawn, the institution must reapply. Procedures shall be those used for initial application.

APPEALS

When an application for accreditation has been withheld or accreditation is to be withdrawn:

(1) The American Boards of Examiners in Speech Pathology and Audiology (ABESPA) will transmit a written report of the accreditation decision to the institution's president or his designee, and the director of the program. The report will include the following information:

(a) An explanation of the bases for the decision to withhold or withdraw accreditation.

(b) A statement that reapplication may be made at any time that the institution or agency believes it has corrected those weaknesses in its program which interfered initially with its receiving approval.

(c) Information concerning the procedures for appealing the accreditation decision.

(d) A statement that if the applicant has not directed a written intention of appeal to ABESPA within 30 days of the date of the written report to the applicant, the decision to withhold or withdraw accreditation will become final.

(2) Appeals of accreditation decisions must be made in writing to the chairman of ABESPA. Each appeal must provide information concerning the basis of the appeal and should include any additional evidence which the applicant wishes to provide.

(3) The chairman of ABESPA will direct the appropriate evaluation board (Education and Training Board) to reevaluate the application, giving consideration to additional information presented in the appeal or subsequently provided by the applicant upon request from the board chairman, and to make appropriate recommendations to ABESPA for action on the appeal. This reevaluation may be carried out by mail or at a regular meeting of the evaluation board.

(4) ABESPA will consider the recommendations of the evaluation board at a regular meeting and take action on the appeal. Representatives of the applicant institution will be provided an opportunity to appear personally at the hearing, at the expense of the applicant, to present oral and documentary evidence.

(5) If the members of ABESPA uphold the decision to withhold or withdraw accreditation, the applicant institution may direct a request to the chairman of ABESPA for further consideration of the appeal by a special hearing panel. This panel will consist of at least three individuals appointed by the chairman of ABESPA and approved by the director of the applicant program. No member of the panel shall have been involved in the original accreditation action or in earlier stages of the appeal process; none shall hold paid or elected office in the American Speech and Hearing Association; at least one panel member shall have had prior experience in the accreditation program; and at least one member shall never have been associated with the accreditation program. The hearing panel will review the appeal and, if specifically requested by the applicant prior to a decision by the panel, hold a hearing at which representatives of the applicant institution and of the ETB may appear to present evidence. On the basis of their review and evidence presented at a hearing, if held, the hearing panel will reach a decision, by majority vote, on the appeal. The decision of the hearing panel is final.

REACCREDITATION

Ordinarily approval is for a 5-year period. However, a program which meets the minimal standards, even though it has some weaknesses, may be approved for a 2- or 3-year period. Increases to 5 years of accreditation from 2- and 3-year approvals may be extended without a site visit at the discretion of the Board.

Approval can be withdrawn if the institution does not continue to maintain an educational program which meets the minimum standards as evidenced by an annual report on faculty, curriculum, relationship to service facilities, and any major changes contemplated. Before the end of each period of approval, the Education and Training Board will make a decision regarding the bases on which revisiting will be conducted, subject to approval of the American Boards of Examiners in Speech Pathology and Audiology.

In the final year of accreditation, the institution will submit a new application in lieu of the annual report. A site visit is mandatory for renewal applications at the end of 5 years.

II. Essentials of an acceptable program of training for speech pathologists and audiologists

INTRODUCTION

Speech pathology and audiology is a field which includes professional services for persons whose educational, vocational, personal, and social functioning and adjustment are impaired by disorders of oral communication. These consist of

disorders of speech, disorders of hearing, and disorders of language. The evaluative and therapeutic services needed by persons with such disorders are made available through a variety of clinical settings, such as programs of special pupil services in schools, clinics established in hospitals, community clinics and rehabilitation centers, and private practice. Irrespective of the particular clinical setting through which such services are provided, the essential knowledge and skills which characterize the person who is competent to provide such services are fundamentally the same and may be briefly summarized under the following five points:

(1) The individual must possess basic knowledge in the sciences and the humanities requisite to an understanding of speech, hearing, and language functions.

(2) The individual must have knowledge of the nature and causes of speech, hearing, and language disorders.

(3) The individual must have a mastery of clinical procedures which will enable the individual to analyze and evaluate the problems presented by persons with such disorders and to devise and carry out appropriate programs of management.

(4) The individual must understand the multidimensional character of disorders of communication and the need for cooperative efforts by allied professional groups (including dentistry, education, medicine, psychology, and social work) in meeting the needs of persons with such disorders.

(5) The individual must be prepared to work as an effective member of an interprofessional team in assessing the problems of persons with disorders of communication and providing appropriate remedial programs to meet their needs.

The Education and Training Board evaluates and approves professional training programs on the basis of their educational effectiveness. It defines educational effectiveness as providing students with the five areas of knowledge and skills that are outlined above, together with such others as may meet the objectives of the institution. In evaluating effectiveness, the board uses as minimum standards the following criteria, which it anticipates will generally result in achieving this goal. An institution whose training program does not meet one or more of these minimum standards will be expected to offer a rationale and/or evidence of equal effectiveness of its differing standards.

STANDARDS FOR APPROVAL

The standards for approval which follow have been established by the American Boards of Examiners in Speech Pathology and Audiology after consultation with interested professional groups both within and outside the field of speech and hearing. These standards are reported below for the information of educational institutions, prospective students, members of other professions, organizations offering services to persons with communicative impairments, and for the protection of the public.

General academic environment

Any program of clinical training in speech pathology and/or audiology must be offered in an institution that has the approval of the regional accrediting agency having jurisdiction in its locality, if eligible for such accreditation.

Administration

(1) Professional training in speech pathology and audiology may be approved only in those accredited colleges and universities with programs that allow students to obtain the master's degree or its equivalent in one or both of these areas.

(2) The general control of the training program by the parent institution must be through a progression of echelons consistent with the organizational structure of the institution.

(3) Within this general framework of academic supervision, the program must have reasonable autonomy and must be under the direct administration and control of a person or persons trained in speech pathology, in audiology, or in speech and hearing science.

(4) The resources necessary for continued operation of the program must be assured through support from the parent institution as indicated by adequate and regular budgetary allocations, procurement of equipment, and allotment of suitable space in ample amount.

Physical facilities

(1) In addition to the classrooms, offices, laboratories, and other facilities essential to any academic program (which are evaluated by the regional accrediting association), the physical facilities for the program of professional training in speech pathology and/or audiology must include equipment, laboratories, and rooms appropriate to the special needs of this field.

(2) The library facilities of the institution must include an adequate variety and number of books, periodicals, and other reference material in speech pathology, in audiology, and in related fields.

Faculty

(1) The director of the program must be a ranking member of the institution's full time faculty. His primary academic training experience, and intellectual commitment shall be in speech pathology, in audiology, or in speech and hearing science.

(2) The faculty conducting the training program must possess the following attributes:

(a) It must include instructors capable of teaching competently the substantive materials of the course of study (background courses, courses in speech and hearing science, and professional courses).

(b) It must include competent persons, with experience both in case management and in student supervision, whose responsibility it is to conduct the institution's program in student practicum and professional service.

(c) The faculty must include persons with interest and ability in research.

(3) A reasonable portion of each student's contacts with members of the instructional staff must be with persons holding full time faculty appointments.

(4) The staff must be large enough to offer each student sufficient personal contact with, and supervision by, faculty members to assure proper instruction in both the classroom and the clinic.

(5) No faculty member shall have a total load (classroom instruction, research, and clinical duties) which is appreciably greater than is dictated by the parent institution's traditions and practice regarding faculty duties.

(6) Rank and tenure of faculty members responsible for this program shall be commensurate with the nature of their responsibilities.

(7) The total program shall be carried out in a manner which allows its faculty and staff effective opportunities for professional interaction, contact with students, and professional productivity.

Educational program

(1) The substantive information encompassed in the curriculum of professional training in speech pathology and audiology shall allow each student to acquire an integrated knowledge of the subject matters appropriate to the area in which he is being trained. The outline below summarizes the scope of this substantive information.

(a) The normal processes and mechanisms of speech, hearing, and language include:

(1) Genetic and cultural aspects of speech and language development;

(2) Linguistic, anatomical, physiological, neurological, psychological, and physical bases of speech, hearing, and language.

(b) The nature of communicative disorders and the principles for their management include:

(1) Classification, causes, and manifestation of the various types of disorders in speech, hearing, and language;

(2) Current principles, procedures, techniques, and instrumentation used in evaluating the speech, language, and hearing of children and audits;

(3) Principles and remedial procedures used in habilitation and rehabilitation of persons with disorders of communication;

(4) Relationships among speech, language, and hearing problems, with particular concern for the child or adult who presents multiple disorders.

(c) Related areas of study include:

(1) Organization and administration of programs designed to provide direct service to those with disorders of communication;

(2) Services available from related fields for those with disorders of communication;

(3) Types of information obtainable from related disciplines, methods for interpretation and effective use of such information, and ways of cooperation with these disciplines in dealing with the sensory, physical, emotional, social, and/or intellectual status of a child or an adult.

(2) The program of professional training shall satisfy the qualitative standards outlined below:

(a) A reasonable amount of instruction in background areas basic to the field (mathematics, the biological sciences, the physical sciences, the social sciences, and the humanities) shall precede professional training.

(b) The professional curriculum shall include a minimum of two academic years, of which at least one year must be available at the graduate level.

(c) The sequence of courses shall be organized so as to give progressive specialization in speech pathology and/or audiology.

(d) The curriculum shall include a reasonable number of advanced courses and seminars to provide an opportunity for the student to become thoroughly acquainted with the literature in the field and with the contributions and thought of contemporary scholars.

(e) The educational program of the student receiving professional training shall include sufficient practicum opportunity to enable him to put into practice the clinical principles and procedures learned in substantive courses, and to enable him to cultivate and develop clinical skills and judgment. Criteria for evaluating the adequacy of practicum opportunities are as follows:

(1) The sequence of professional participation (including observation and supervised practicum) must extend over a minimum of a year and a half.

(2) The program must ensure the student opportunity to observe procedures of evaluation and case management by qualified clinicians.

(3) The practicum must provide experience with various ages and types of communicative disorders.

(4) The practicum must provide experience with the equipment essential for the conduct of clinical services.

(5) Practicum in a particular area of disorder must be preceded by or be concurrent with substantive instructions in this same area.

(6) Practicum must be adequately supervised. Supervisors of clinical practicum must be competent professional workers who hold the Certificate of Clinical Competence or equivalent in the professional area (speech pathology or audiology) in which supervision is provided. This supervision must entail the personal and direct involvement of the supervisor in any and all ways that will permit him to attest to the adequacy of the student's performance in the clinical training experiences. Knowledge of the student's clinical work may be obtained through a variety of ways such as conferences, audio and video tape recordings, written reports, staff meetings, and discussions with other persons who have participated in the student's clinical training, and must include direct observation of the student in clinical sessions.

(7) The institution shall maintain adequate records to document the details of the practicum experiences of its students and must have an efficient procedure for reporting this information when it receives warranted requests for it.

(3) The program for student observation and practicum shall meet the following criteria:

(a) Each service facility utilized must be adequate for student observation and practicum, as confirmed at the time of the evaluation of the entire training program in speech pathology and/or audiology and conducted by the same site visit team performing the overall evaluation.

(b) The composite of all facilities utilized for such training must possess an appropriate and adequate scope of evaluative and therapeutic services covering a wide variety and amount of case material.

(c) The composite of all facilities must offer opportunities for experience in interdisciplinary activities under a diverse professional staff, as well as opportunities to learn the principles of collaborative interaction with other clinics and with allied professions.

(d) Each facility must be conducted in a manner and under circumstances that will make it freely available for the instruction of students in training, and which will in other ways integrate it effectively into the teaching program.

(4) The educational program shall have sufficient scope that within a reasonable length of time, by proper selection of courses and practicum experiences, a student can satisfy fully the academic and practicum requirements for the Certificate of Clinical Competence awarded by the American Speech and Hearing Association.

Student body

(1) The students allowed to enroll in the program must be held to requirements for admission that are at least as high as the general standards for admission which the institution maintains for students in its other areas of study of comparable academic level.

(2) The institution must have graduated a minimum of six students, at the master's level, in the area for which accreditation is sought within the three-year period prior to submitting application for accreditation.

Admission to the approved list

(1) Application for approval of a program for professional training in speech pathology and/or audiology shall be made to the American Boards of Examiners in Speech Pathology and Audiology of the American Speech and Hearing Association, 9030 Old Georgetown Road, Washington, D.C. 20014.

(2) An institution with an approved training program must report annually on any major changes that have occurred in its faculty, its curriculum, or its relationship to service facilities, as well as any major changes that are immediately impending. If these changes are sufficiently extreme, they may require a site visit. Ordinarily accreditation will be for a period of five years. Before the end of each two- or three-year period of approval, a decision will be made by the Education and Training Board, subject to the approval of the American Boards of Examiners in Speech Pathology and Audiology, regarding the bases on which revisiting will be conducted.

(3) Approval will be withdrawn if the institution does not continue to maintain an educational program which meets the minimum standards outlined above.

ITEM 6. PREPARED STATEMENT OF DAVID M. RESNICK,* PH. D., DIRECTOR, HEARING AND SPEECH CENTER, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C.

Mr. Chairman and members of the subcommittee: I would suspect that one of the reasons for my being invited to submit a statement to this Senate hearing has to do with my direct involvement in the provision of clinical services to the hearing impaired public, and perhaps more specifically because of my experiences concerning the delivery of hearing aids to those whose hearing limitation can be benefited only through the use of hearing aid amplification.

From the statements and testimony provided to this subcommittee in 1968, as well as other indications preceding and following that year, it is apparent that there is strong difference of opinion between the commercial and professional participants relative to the effectiveness of methods involved in the delivery of hearing aids. These differences are not new, and to many of us at the grassroots level the multiplicity of problems associated with the provision of hearing services and hearing aids represent an occupational hazard that must be dealt with daily. The solution to one operational problem seems to foster the development of others, and the quest to better the system never seems to reach maturity. We have yet to arrive in the 20th century with the provision of hearing aids, and the desires of the commercial and professional communities continue to tug in opposite directions.

For example, the commercial camp is perfectly satisfied with the present delivery method. The industry describes the system as more than adequate to meet the needs of the hearing impaired population. Conversely, the professional camp continues to press for greater evaluative assessment prior to the fitting of a hearing aid, and more adequate rehabilitative services following provision of the instrument, all hopefully at lower cost. It is this "lower cost" tenet that is frightening to industry.

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*See statement, p. 34.

The hearing aid industry will have delivered well over half a million hearing aids by the end of 1973. Easily 75 percent of these instruments will have been placed in the ears of the consumer by a hearing aid dealer without benefit of referral from, or to, a medical or audiological practicioner. The industry justifies this situation in the name of "service"—a service, they say, which by virtue of the vast dealer network can be brought to the consumer's doorstep. Medical practicioners and audiology centers, industry feels, are stationary—the consumer must go to them, and there is little motivation for action in this direction. The suggestion is true as far as it goes. Unfortunately it does not recognize the trend toward more hearing impaired persons seeking professional help prior to hearing aid use. By industry's own statistics 10–20 percent of the aids sold several years ago were from direct professional referral. Today approximately 25 percent of sales are the result of professional recommendation.

Another reason for industry's preservation of the status quo becomes apparent when one realizes that the consumer will place in excess of $150 million in the hearing aid market this year. In addition, industry estimates that 5 million hard of hearing individuals could benefit from the use of hearing aid amplification. The statistic may be doubtful, but taking it at face value this calculates to about $1½ billion worth of instruments at today's average retail cost to the consumer. That potential is carrot enough for industry to protect under any pretense, by whatever means.

The National Hearing Aid Society (NHAS), that organization which represents the purveyor of hearing aids to the public, continues to resist alteration of the delivery system by citing that in most States hearing aid dealers are licensed to do what they do, that they continue to upgrade their trade by in-service education programs, and that they are more than willing to cooperate with medical and audiological practictioners in the business of putting hearing aids on their patients, as long as the amalgamation allows them to place hearing aids on that 75 percent of the hearing impaired population which comes to them directly, or which they earnestly seek out.

It is true that most dealers approve a modest discount to professional referrals, but no matter how knightly the gesture the practice still provides a liberal margin over manufacturer cost. The professional discount sales price in most instances does not realistically reflect the time and effort saved the dealer. Neither, in many cases, does it reflect the fee charged by the professional for services rendered in connection with the provision of the hearing aid recommended.

The high prices charged by dealers and the questionable sales practices utilized by many of them have received ample coverage in the 1962 Kefauver hearing, the 1973 report of the Minnesota Public Interest Research Group, and various newspaper articles including the Minneapolis Star, The New York Times, and The Baltimore Sun. This literature suggests rather firmly that the hearing aid dealer's place in the sun is becoming clouded with the issues of realism.

Recent legislation enacted in the State of Minnesota which prevents a hearing aid dealer from initially selling a hearing aid to anyone under 18 or over 60 except on the prescription of a medical or audiological practictioner is sound evidence of one State's response to the need to better the services to the hearing impaired. FTC action against several hearing aid manufacturers to desist from exclusive sales territory agreements is but another example.

For further evidence of change one need only be aware of the increasing number of alternative plans for providing hearing aids to the hard of hearing. Reference is made here to such businesses as Behavioral Prosthetics, Inc., presently operating in Utah and California, and Master Plan Service Co., with offices in Minnesota, Wisconsin, Illinois, and Washington, D.C. This subcommittee will have before it detailed descriptions of these operations and no attempt to describe them extensively will be undertaken here. There are, however, two important facets to each of these systems which are critical to the deliberations of this subcommittee. First, each system provides hearing aids at a cost substantially below that charged to the consumer through the present dealer delivery system. Master Plan Service operates with a price structure ranging from $99 to $199, for example. Second, hearing aids are sold through professional referral only, i.e., no diagnostic testing is performed by the vendor—all testing must be accomplished by the professional prior to the provision of a hearing aid. Through both systems the potential hearing aid user is provided a professional evaluation

by persons exquisitely trained to conduct it, professional hearing aid selection from persons unbiased by product involvement, and professional rehabilitation services from individuals highly schooled in the techniques needed to cope with the problems of the hearing impaired.

There are other alternative delivery plans in existence, also. For instance, a hearing and speech program in Canada salaries a hearing aid dispenser as part of the staff. The dispenser does no testing or rehabilitation, but simply provides, at markedly reduced cost, the instrument recommended by the audiologist.

Some hearing aid dealers are offering large discounts on instruments as a means of ensuring their relationship with the professional community. In Detroit this practice has merely succeeded in producing a price war, and although consumer cost of hearing aids is less the delivery system has not been altered to services to the hearing impaired.

In testimony presented before this subcommittee in 1968 Dr. Kenneth Johnson, executive secretary of the American Speech and Hearing Association (ASHA) proposed a State-Federal plan of procuring and issuing hearing aids similar in scope to the Veterans' Administration program, but applicable to title XVIII and title XIX beneficiaries. The advantages of such a program are threefold:

(1) A reduction in the costs of hearing aids purchased by the Government.

(2) The provision of adequate diagnostic and rehabilitative services, with the assurance of objective hearing aid fitting to beneficiaries.

(3) The elimination of sharp sales practices and misleading advertising.

The same advantages describe the Master Plan Service Co. and Behavioral Prosthetics programs, and these programs would be applicable to other potential hearing aid users who do not qualify as beneficiaries under titles XVIII or XIX provisions. Master Plan and Behavioral Prosthetics are in operation providing measured benefits, within confines imposed by the industry, to those in need of hearing aids. These programs, as well as the State-Federal hearing aid procurement proposal suggested by Dr. Johnson have direct application to the concerns of this subcommittee, i.e, they provide improved services to the hearing impaired elderly at lower cost, and protect the consumer from being sold a device inappropriate to the problem.

The 20th century beckons the hearing health community, and it is time that those responsible for health care recognize the shameful inadequacies in the practices surrounding the management of hearing loss. It is time for controls to prevent those whose chief concern is selling for profit from independent involvement in what is primarily a rehabilitative problem. It is time to realize that a physician specializing in ear problems is the only one qualified to diagnose the source of hearing impairment; that an audiologist is the only one qualified to evaluate the integrity of the auditory system and recommend hearing aids objectively; that a hearing aid dealer should be confined to the provision and servicing of hearing aids on prescription. Any other role in the hearing health program is beyond the scope of his expertise, and will do much to continue the high cost of hearing health to the elderly.

ITEM 7. LETTER AND ENCLOSURE FROM DAVID M. RESNICK,* PH. D., DIRECTOR, HEARING AND SPEECH CENTER, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C., TO SENATOR FRANK CHURCH, DATED SEPTEMBER 14, 1973

DEAR SENATOR CHURCH: . . . I submit this letter partially in rebuttal to industry testimony and partially as addendum to my own verbal remarks before the subcommittee.

To begin I must reiterate that the present method of delivering hearing services and prosthetic devices to the majority of the hearing impaired lacks professionalism, is devoid of objectivity, and is economically unjustifiable. To compare the recommendation and sale of hearing aids by a hearing aid dealer to the prescription and sale of eyeglasses by an optometrist, as Mr. Miller was doing during his questioning, is a totally unrealistic paradigm. Opthalmologists have stated to me that some optometrists will prescribe glasses for patients even when they would not. That may be the only similarity between the hearing aid dealer and the optometrist, i.e., the potential conflict of interest resulting from product involvement.

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*See statement, p. 34.

There are many dissimilarities, however. One of these, as I mentioned in direct testimony, is the training afforded the hearing aid dealer compared to the optometrist, or to be more specific, the audiologist. The optometrist is exposed to rigorous academic and professional education, as is the audiologist, spanning in many instances several years. No matter how emphatic the National Hearing Aid Society (NHAS) appears concerning their efforts to elevate the education of the dealer by in-service education, workshops, seminars, and home-study courses, the aggregate of their professional training in no way equals the academic and practicum experience of the certified clinical audiologist.

The hearing aid dealer is first and foremost a salesperson—trained and, hopefully, skilled, to sell a product, not a service. As a result of selling the product the salesperson must provide a service or the sale doesn't stick. It is much the same as sewing machine dealers who provide service for the machines they sell. They even provide a few free lessons just in case you don't know how to sew after you've purchased the machine. The lessons aren't really free, of course. They're built in to the price of the sewing machine. You pay for them whether you go to sewing class or not.

If hearing aid vendors were earnest about selling hearing and not just hearing aids they would not try to sell an instrument to every person who enters the salesroom complaining of hearing difficulty. A successful hearing aid dealer once told me that a good salesperson can "sell" seven out of ten clients, and that if a salesperson can't reach this level of sales proficiency in three months he is of little value to the business. What, then, does the vendor who is so quick to point out that he sells hearing not hearing aids do for the customer to whom he can't sell an instrument? Does the vendor send the customer to a physician? Probably not. To a psychiatrist, a neurologist, an audiologist? Does the salesperson provide counseling or hearing therapy? Probably not. That service by and large only comes with the hearing aid. In any case you pay for it with the aid whether you take it or not.

Mr. Miller extracted a statement from me concerning the fact that I would not be satisfied with hearing dealers as a group even if they were trained to the same degree as optometrists or audiologists. In retrospect, I must stand on the negative answer given in testimony. There are hearing aid dealers who hold master's degrees in audiology, but most of these were hearing aid dealers first and audiologists later in life. Although I am more comfortable with this kind of a person I am to a large degree wary of product-oriented people in the health care field. When the decision regarding the benefits to be derived from the use of a product is entrusted to the individual who stands to reap financial gain from the sale of that product there is a resulting bias that simply cannot be defended. This is true in private industry, in government, and in health care. Objectivity is lost in such instances and public trust is weakened. It is indeed for these very reasons that political appointees are requested to divest themselves of financial holdings that pose potential conflicts of interest.

Mr. Oriol questioned the nature of the Task Force on the Dispensing of Hearing Aids by audiologists which was formed by the American Speech and Hearing Association (ASHA). As an individual I am opposed to audiologists selling hearing aids for the very reasons cited above. If permitted to sell as an audiologist I believe I could be objective and would have the integrity not to sell a hearing aid if it were not indicated. I would not, however, relish challenging that integrity several times each day in the face of sales quotas, rents, overheads, and dreams of tropical islands. As an audiologist and a member of the Dispensing Task Force I am, nonetheless, interested in the concept of audiologists dispensing since it represents a possible alternative, another choice on the part of the buyer, to the present system of purchasing a hearing aid—perhaps at a lower price. In addition, and more importantly, it provides substantial improvement in the quality of service. The concept is sound, but if adopting a position which would allow audiologists to dispense compromises the objectivity upon which the profession of audiology is built, then the concept can never reach fruition, and we must live with the system presently at hand.

More must be said in reference to the number of hearing aids manufactured. There are approximately 50 manufacturers producing in excess of 375 models of hearing aids, of which the Veterans Administration (VA) utilizes about 30. Stated differently, out of over 375 models of hearing aids the VA has selected 30 as sufficient to meet their needs. True, not all models of available instruments are submitted for VA acceptance, but the fact is clear that the needs of an organization that dispenses 11,000 aids annually can be adequately served with less than one-tenth of the available number of models. My position in direct testi-

mony was that the industry is overproduced. There is no other product where the consumer has such a wide choice. No research has demonstrated that such a varied selection is needed. To the contrary, the largest single consumer of hearing aids, utilizes only 30 different models. And yet the industry continues to produce more than 375 different kinds of hearing aids. What kinds of things cause overproduction? Low manufacturing costs with high retail price? Demand? Are all manufacturers financially stable, or are some companies feeling the pressures of an overproduced business.

There are certainly enough hearing aid models to meet the needs of the hearing impaired. The fact of the matter is there are too many, and this may be one of the factors that keeps the price of instruments high to the consumer. But I will have more to say on the economics of the present delivery system further on.

I must for the moment turn to the testimony provided by the NHAS and the Hearing Aid Industry Conference (HAIC). Throughout much of the direct testimony presented by the commercial interests you heard that hearing aids can not be fitting, or prescribed, in the same sense as eyeglasses are prescribed. Despite technological advances by industry this statement remains true even today. One can not "grind" a precise prescription of decibels for auditory amplification in the same fashion as one can arrive at the precise number of diopters needed for visual magnification. The very nature of the two stimuli, i.e., sound and light, is sufficiently different to limit the manner by which each can be handled. In addition, the two sense organs, the eye and the ear deal with incoming stimuli in completely different ways. The selection and fitting of a hearing aid is, as Mr. Pigg pointed out in his presentation, an art not a science. The testing of that instrument as to the auditory benefit derived by the user is however, more a science than an art. Most dealers accomplish no scientific, psychoacoustic testing of the hearing aid fitting, and the art which they do apply is the art of salesmanship. The system requires it.

The subcommittee is undoubtedly aware of the American National Standards Institute (ANSI) publication S. 3.1 (1971) relating to background noise in audiometric test rooms. It has direct application and pertinence to testimony presented by Terry Griffing relative to the validity and reliability that can be expected from hearing tests conducted by hearing aid vendors. In part the document states: "It is desirable to have a uniform set of criteria for the sound pressure level of background noise that is allowable in a room used for audiometric tests. Such criteria make it possible for the designer to plan appropriate acoustic treatment and for the user to assure himself of reasonably quiet testing conditions".

Mr. Griffing suggested that the dealer in hearing aids is competent to evaluate the capacity of the auditory system. In answer to your question, Senator Church, he affirmed that the audiometer was capable of delineating possible underlying disease. Obviously from the ANSI document the audiometer is only one portion of the requirement for adequate hearing testing. Test environment is critical, and specified conditions must be available. These specified test conditions can not be met when a portable audiometer is carried into the home of a hearing impaired person. Neither are the ANSI requirements for hearing test rooms complied with in dealer's offices. Every accredited hearing and speech center meets the specifications for audiometric test rooms, however.

Mr. Griffing further suggests that the dealer who tests hearing for the purpose of selecting a hearing aid can be adequately alerted to etiologic disease from a check list provided him by a physician. The position is weak. There is simply no way that a cursory test, performed under inadequate environmental conditions, can be an accurate indicator of disease. How, for example, would such a simple test performed by a dealer portend the existence of venereal disease as the cause for diminished hearing? The presence of a brain stem lesion, temporal lobe epilepsy, etc.? One must not lose sight of the fact that hearing loss is a symptom of potential disease and as such it must be adequately evaluated, not simply tested for the purpose of selling a hearing aid.

Dr. Robert Reuben suggested in testimony that the training afforded the hearing aid vendor was not sufficient to provide adequate evaluation of auditory functioning. Dr. Reuben also indicated that a master's degree in audiology was perhaps excessive to the needs. I would hasten to bring to the attention of the subcommittee the experience of the VA in the business of hearing testing. In the 1940's the VA spent literally millions of dollars in hearing loss compensation based on hearing test results obtained by minimally trained audiometrists. Today the VA employs audiologists with master's degrees to conduct and supervise the

hearing tests which form the basis for compensation. Through the use of highly trained audiologists the flow of compensation dollars for hearing loss claims has been substantially reduced, disease produced hearing loss has been accurately diagnosed and treated, and still 11,000 veterans have been fitted with appropriate amplification.

Concerning the "certification" of dealers by the NHAS, and the value of State licensing, it should be realized that only about 2,000 of the 10,500 hearing aid vendors are considered certified by the NHAS. These are the only members whom the society has any control over. Thirty-six States have legislated licensing of hearing aid dealers. This, the industry feels, speaks well of the effectiveness and control of the service system. One must ask, however, how many grievances have been filed against dealers? How many licenses have been revoked? How many certificates have been suspended because of proven unethical conduct? The industry is anxious for it to be known that in more and more States dealers are becoming licensed, and that more and more workshops are offered to dealers each year. They are remiss in pointing out that these workshops are in most instances taught by audiologists; that not a single dealer license has been revoked—not because of a dearth of infractions—but rather because the consumer does not know how to file a grievance; that if certificates are suspended by the NHAS the vendor continues to operate his business in his desired manner. The certificate is like the gold star the teacher stuck on your forehead in the first grade when you spelled a word right. If you were lucky and the star stayed on overnight you could fool your mother into thinking you spelled correctly 2 days in a row. Nobody really knew except your school chums and they wouldn't tell because someday they might try to use their own sticky star two days in succession.

I would like now to turn to the cost factor and set the tone by simply stating "you pay for what you get." The NHAS justifies the selling price of a hearing aid through listing ingredients such as equipping, staffing and operating an office, employees salaries, testing, licensing fees, taxes, advertising, continuing education, time involved in counseling, etc. The dealer calls this "markup" over manufacturer cost, not profit. In fact nowhere in the list of markup ingredients does the dealer include a fair profit item. The society would have you believe that a dealer merely marks up the instrument to cover the costs incurred in handling it and makes no profit. It is interesting to note that the same markup applies when the purchaser buys one or two aids, the first, second or tenth instrument. Yet it would seem obvious to the most casual observer that two aids do not require twice as much counseling, instruction, etc., as one, and certainly the second and subsequent instruments purchased do not require the same hand-holding and after-fitting care as the first fitting. A $50 trade in allowance is not a great deal and is a rather telling figure. It suggests that the testing, selection, instruction, and counseling is not worth more than the other overhead expenses built in to the price of the hearing aid. This is probably the real reason a hearing aid dealer is reluctant to break the price of component services out of the total charge for the instrument.

If one uses the average manufacturer cost to the dealer of $100 and adds to that the fees charged by audiologists for professional services rendered there is little chance that the total cost would exceed $210. Remember, with a professional dispensing system the patient only pays for what he gets, and what he gets is objectivity and the required professional care. I have attached to this addendum an exhibit which portrays the charge for hearing services including a hearing aid under three different delivery systems.* The charges are based on dispensing the same instrument. It is possible to effect considerable savings by altering the delivery system as seen from the chart.

The criticism that there are insufficient audiologists or centers to serve the population is not a valid one. There are approximately 560 PSB accredited hearing and speech programs in the Nation. The VA has dispensed 11,000 instruments through 40 centers where audiologists devote only one-fifth of their time to services related to hearing aids. With 14 times the number of centers devoting even one-half time to hearing services it would seem reasonable to assume that the population in need could be served. The question as to how people in rural areas receive service cannot be answered satisfactorily, except to say that the procedure selected to provide care cannot sacrifice quality of service for quantity. What is best for the most number of people must prevail. The present delivery

*See table, p. 130.

system, although it currently serves the most number of persons, does not service them in the best, most economical way.

The subcommittee has perused the methods and procedures of Behavioral Prosethetics, Inc., and Master Plan Service Co., as examples of alternative delivery systems. The efforts of these companies and any others like them should be applauded, not thwarted. These companies are attempting first to place the professional rehabilitation of hearing loss at the doorstep of those best suited to deal with it; to enhance objectivity; and, to lower the price of the prosthesis. The companies' endeavors to accomplish an alternative delivery system are being stunted by the very groups, i.e., dealers and manufacturers, who entone so plainly that their chief concern is service to the hearing impaired, that consumer costs are fair—there is no profit, just markup, and that there can be no improvement in the present system for it is already the best there is.

James Ince of HAIC testified that manufacturers do not uphold exclusive franchising of dealers. He implied that manufacturers will sell to any dealer. The facts of the matter are that companies such as Master Plan and Behavioral Prosethetics cannot obtain the variety of instruments of their choice because the factories will not sell to them; the FTC is currently investigating five manufacturers who allegedly maintain exclusive territory (two have already signed consent orders); and, dealer organizations exert substantial pressure on manufacturers to preserve their "one of a kind" sales office.

Mr. Ince suggested in direct testimony that a search of the Washington, D.C., yellow pages might reveal as many as two dozen hearing aid dealers. The statement was made to emphasize the competitiveness of the hearing aid business. A search of the yellow pages will reveal many things: Violations of the dealer's stated code of ethics concerning advertising; confusing and misleading terminology; each brand represented by essentially one dealer; not all of the dealers are certified. What the yellow pages really suggest is that the control exercised by the industry is somewhat superficial. It would also appear that the industry, at least at the dealer level, is afraid of the kind of competition offered by alternative systems such as Master Plan. The dealers don't mind vying to sell one brand against another when both are competitively priced with a 300-percent markup. They do mind the kind of competition created when a dealer penetrates the market by selling identical brands at only a 40-percent markup.

Again it becomes evident that the consumer is caught in the purchase of hearing health in a predicament unlike any other. For example, a consumer wishing to buy a particular model car can choose to make the purchase from the dealer that offers the best price, or a patient can fill a medical prescription at a cutrate pharmacy, or buy a Zenith TV at a discount store. The hearing aid purchaser is denied a choice, he must pay the price the dealer asks, for that dealer is the only one selling that aid, and most of the other aids (should they be appropriate to the hearing loss) are about the same price. If the patient can't afford the price he doesn't buy the aid—the dealer doesn't sell him hearing. This is the system that industry states is best. This is the one that the dealers press to preserve. It is the technique of forced choice.

The whole issue of who is competent to provide the best service recognizing the need for objectivity and economy seems absurd, but it is an issue that has doggedly characterized most health care endeavors. Consider, for example, the golden years when the local barbershop performed surgery; the days of the old family physician who rode miles in a horse-drawn carriage to set a broken arm, draw blood or deliver a baby. Several years ago most babies were delivered by midwives, some babies were delivered by general medical doctors, and no babies were delivered by obstetricians. Today, as needs have changed and roles have been defined by public education and freedom of choice, a pregnant woman can choose to have her baby delivered at a hospital with medical help, or she may have a midwife come to her home. She may also select no outside help at all.

Granted, most pregnancies today are managed by obstetricians, but through education the public has made that choice. The obstetrician is a relative newcomer, but the analogy of his struggle for position may apply to audiology. Imagine the absurdity of the obstetrician being told:

(a) "Let's define the role. We midwives will allow you to diagnose the pregnancy, and possibly prescribe medication, but you then must turn the patient over to us for delivery of the baby and post-natal care."

(b) "You can contribute more by restricting yourself to research and teaching. Your extensive education has made you a major leaguer. Delivering babies is just minor league stuff that would not challenge you."

(c) "Midwives are much better qualified to deliver babies. After all, we have been delivering babies since childbirth began. Besides, there are more of us and we are better distributed geographically throughout the country. There are fewer obstetricians, and they are concentrated mainly in the urban centers and close to universities."

(d) "You really would not want to do all the hand holding that we do, nor drive the many miles to visit patients in their homes. Mothers are difficult to care for, they are temperamental, they cry a lot and sometimes scream during the delivery. Besides, the delivery is messy, . . ." ad infinitum.

Is it not just as absurd when hearing aid dealers try to define the role of the otologist or the audiologist? Each field counterbucks by defending its unique qualification to enter the arena. The physician says that it doesn't require a master's degree to test hearing. Records of the U.S. military reveal that it doesn't require a medical degree to perform an appendectomy. It probably doesn't—unless something goes wrong. And who knows when something is going to go wrong, or what to do when it does? The doctor, and we're all thankful for that state of the art. That's precisely why a physician will be the one to remove my appendix should the need arise, and not my neighborhood pharmacist. Not only is the physician skilled in the techniques required to do the job, as the audiologist is trained to perform his duties, but he will give me objective advice whether my appendix has to be removed or not.

Childbirth is, of course, a natural phenomenon and it is easy to accept the freedom of choice available to pregnant women. Should medical drugs be required, however, a physician must be consulted to sign a prescription. So the choice may not be quite as broad as it appears. Similarly, one cannot obtain eyeglasses initially from an optician. The visually impaired must enter the system at the level of the optometrist or the ophthalmologist. But with hearing aids we continue to uphold a system wherein the hearing impaired is able to consult a physician, an audiologist, or a vendor; and no matter where the entry, they will all end up with the vendor—even the 25 percent who seek professional help first.

The education afforded the hearing impaired has done little to improve the situation. If the Government is going to subsidize hearing aids for the elderly it must require unbiased determination of the need for the prosthesis, as well as objective selection of the instrument. The point of entry into the delivery system must be specified, and it must avoid the purveyor of the product as the initial contact.

The VA has demonstrated the advantage of utilizing trained clinical audiologists to select and fit hearing aids and evaluate the auditory system. The hearing aid industry through its behavior and from testimony before this subcommittee suggests that there is nothing to be gained by alteration of what is ostensibly a perfect system, and whatever small imperfections do exist they will alleviate with their clean business practices, certificates, licenses, and sense of fairplay. This, they feel, is the Promised Land. In truth it is the Land of Consumer Chaos, and it must be improved.

The data from many experts are available. The subcommittee must glean the facts from the half-truths, the isolated instances from the general practice, the needs from the desires, and enact into law a system which ensures objective, economical hearing health for the most number of older Americans. The task is not easy, but those of us in the professional community are confident that the subcommittee will consider every aspect of the testimony presented and act in the best interest of this Nation's elderly citizen.

Very truly yours,

DAVID M. RESNICK, Ph. D.,
Director, Hearing and Speech Center.

Enclosure.

ESTIMATED CHARGES FOR THREE METHODS OF DELIVERING HEARING SERVICES INCLUDING PROVISION OF THE HEARING AID

Service	Methods		
	Present delivery system	Master Plan system	State/ Federal procurement
Physician's fee	$20.00	$20.00	$20.00
Diagnostic audiologic examination	20.00	20.00	20.00
Hearing aid evaluation	25.00	25.00	25.00
Aural rehabilitation	20.00	20.00	20.00
Subtotal (2 visits)	85.00	85.00	85.00
Hearing aid	[1] 389.50	[1] 189.00	[2] 114.50
Less 20 percent discount	77.90	([3])	([3])
Actual charge	311.60	189.00	114.50
Earmold	([4])	12.50	7.00
Total	396.60	286.50	206.50

[1] Charge based on current consumer cost of an available behind-the-ear model hearing aid.
[2] Charge based on manufacturer's price to dealer when purchased in single unit lots.
[3] Not available.
[4] Usually included.

ITEM 8. LETTER FROM DAVID M. RESNICK,* PH. D., DIRECTOR, HEARING AND SPEECH CENTER, WASHINGTON HOSPITAL CENTER, WASHINGTON, D.C., TO SENATOR FRANK CHURCH, DATED SEPTEMBER 19, 1973

DEAR SENATOR CHURCH: In your letter of September 15 you asked: "Of the (approximately) 350 models of hearing aids available how many are essentially different and not duplications of pre-existing models?"

I am unable to provide you specific numbers in answer to your question. At any given point in time there are always a few manufacturers who lead the pack with inventiveness, ingenuity, and nuances of one type or another. It does not take long, however, for the followers to keep pace with the leaders and real differences among hearing aids are nonexistent for any appreciable period, despite advertising claims to the contrary.

Almost all manufacturers market a body-worn model, a behind-the-ear instrument, an eyeglass aid, and in-the-ear model, a bone conduction aid, and some an economy model. Most manufacturers also cover the gamut of mild, moderate, and high power aids, encompassing a frequency response range that spans 300–3,000 Hz, emphasizing various critical points within that range by and large. Most of the models incorporate in the design a variety of adjustments and/or accessories that enhance the suitability of an instrument to a particular hearing loss. The combination of adjustments, accessories, and models results in a permutation that boggles the mind. I submit that this is a detriment to the industry, rather than a benefit.

In support I would call your attention to the Veterans' Administration. Through audiology centers the VA issues about 11,000 hearing aids annually. These aids come from a pool on the order of 30 different models. There are two significant points here:

(1) The VA can objectively fit 11,000 hearing aids from an inventory of 30, not 350, models. This is a formidable sample which suggests an apparent duplication of models, or a lack of need for so many.

(2) The 30 models that comprise the VA sample come from approximately 18 manufacturers, and in no case are all models produced by any one manufacturer utilized. This is an extremely telling fact which suggest that a small number of manufacturers can produce a limited variety of models to satisfy a substantial number of hearing impaired persons—and audiologists who fit them.

I might point out that one of the leading manufacturers does not have an instrument included in the 30 VA models. This may be of the manufacturer's choosing. The point is clear, however, that with none of the leading manu-

*See statement, p. 34.

facturer's models represented the VA is able to meet the auditory needs of its population.

The above information tends to suggest considerable duplication of hearing aid models among manufacturers, and further emphasizes the capability of a relatively few models to meet the needs of a rather large group of hearing impaired.

Very truly yours,

DAVID M. RESNICK, Ph. D.,
Director, Hearing and Speech Center.

ITEM 9. PREPARED STATEMENT OF DR. ROY F. SULLIVAN,* PH. D., ASSOCIATE PROFESSOR, DEPARTMENT OF SPEECH ARTS AND SPEECH PATHOLOGY/AUDIOLOGY, ADELPHI UNIVERSITY, GARDEN CITY, N.Y.

It has been 5 years since I appeared before this subcommittee to give testimony concerning hearing aids and the elderly. Considering the basic issue of the potential inclusion of prosthetic amplification under the purview of title XVIII, Medicare, I would like to comment on what I perceive to be the most significant developments, relative to the needs of the aging hard-of-hearing consumer, which have occurred in the intervening period of time.

As was the case prior to 1968, I have been involved, subsequently, with the audiology program at the Long Island College Hospital in Brooklyn, N.Y. There, we serve the needs of a predominantly geriatric hearing impaired population. The majority of these patients, in turn, have surgically inoperable, sensory-neural losses of hearing. My comments, through experience with these patients, pertain specifically to the areas of technological advances in hearing aids, public assistance and distribution systems.

TECHNOLOGICAL ADVANCES IN HEARING AIDS

Advances in the design and performance characteristics must be credited to the hearing aid industry. This not only includes manufacturers of hearing aids but also of transducers (i.e., microphones and receivers), component parts, batteries and earmolds. Additionally, one must cite the contributions of manufacturers of packaged integrated circuits, Bell Laboratories and the profession of audiology.

Hearing aids consist, basically, of a microphone, amplifier, receiver, battery, and some means of transmitting sound to the ear, such as an earmold and polyvinyl tubing. Those with more severe hearing impairments may also require a telephone coil within the hearing aid, as well (in a recent study in England, 50–75 percent of adults with impairments in hearing ordinary conversation claimed not to be able to use the telephone).

(1) Integrated circuits (IC's). The amplifier section of hearing aids has reached the stage of development in microminiaturization and mass production that, in some cases, it has become economically more feasible to replace an entire IC than "trouble shoot" and repair it. A number of instruments of American manufacture have been marketed recently with "plug-in" IC electronics. This permits the hard-of-hearing consumer to return his defective instrument to the dealer for virtually immediate repair or replacement of the critical components. Also, both size and weight of eyeglass and behind-the-ear models have decreased, while the amount of available amplification has effectively increased to the 60 decibel range. Consequently, hearing losses which would have required a body-worn hearing aid, 5 years ago, can easily be fitted with an ear level instrument at the present time.

(2) Microphones. (a) Ceramic microphones. Available in 1968, use in subsequent years had become widespread. The effect was a smoother, more extended frequency response for hearing aids. (b) Electret microphones. Based on a principle developed at Bell Telephone Laboratories, this recent innovation in hearing aid transducers has a very low intrinsic mass with reduced susceptibility to shock and mechanical vibration. It presents a low distortion, smooth frequency response with sharp transient response. (c) Directional microphones. Directional effects have been claimed for hearing aids for many years. These, in fact, have

*See statement, p. 40.

ranged from minor to nonexistent. However, the new rear port directional microphone permits, for the first time, as much as a 20 dB difference in amplification between sounds originating in the front (louder) versus the rear (softer).

(3) Earmolds. Of all recent technological advances in prosthetic amplification, the one which I consider of greatest import to the geriatric hearing-impaired consumer is the open mold or no-mold (nonoccluding) fitting. It was originally conceived by Harford and Barry, two audiologists at Northwestern University, in the context of a means for compensating unilateral deafness in face of normal hearing in the opposite ear. Subsequent research by Harford; Green et al., has shown the basic principle of the nonoccluding earmold to be applicable in a wide variety of hearing loss conditions.

While used in less than 13 percent of our hearing aid fittings at the Long Island College Hospital Division of Audiology in 1968, nonoccluding fittings now constitute 75 percent of our recommendations to the elderly. The practical effect of this particular mode of coupling the hearing aid to the ear has been to vastly increase, in my opinion, the proportion of the geriatric population who may be effectively aided by prosthetic amplification.

The basic advantage of this nonoccluding coupling technique is that amplified sounds of frequencies below 1,500 Hz, which contribute the bulk of loudness but little intelligibility, are vented outward from the ear canal. Sounds above that frequency are directed effectively toward the eardrum. In addition, the nonoccluding fitting offers no opposition to the flow of unamplified sound from the environment into the ear canal, directly.

This fitting is ideal for the needs of the geriatric patient with a characteristic higher frequency loss of hearing with little tolerance for loud or extraneous sounds. There is also a certain rigidity which makes him more accepting of an aid if the ear is unoccluded, rather than blocked by a standard hearing aid earmold.

For milder losses, a single, behind-the-ear instrument with nonoccluding mold will suffice. However, for moderate-to-severe losses, it becomes necessary to CROS (contralateral routing of signal) the aid in order to physically separate microphone from receiver and thereby reduce acoustical feedback which appears at the required higher amplification levels. There are many possible configurations of open mold fittings. My most successful clinical experience with this principle, in recent times, was the CROS fitting of an 83-year-old man who had continuously tried and rejected all other forms of amplification over the last 20 years.

In summary, as hearing aids have improved in quality, gain, size, imperviousness to damage, ease of repair and especially, because of nonoccluding fitting, acoustical appropriateness to the hearing loss of the hearing impaired elderly patient, the technology may be rated as extremely compatible with the needs of this worthy population.

PUBLIC ASSISTANCE AND HEARING AIDS

According to industry estimate, 600,000 hearing aids were sold last year in the United States. Sixty-nine percent were sold to customers who had consulted neither an otologist nor an audiology clinic. Audiology clinic referrals constituted 15 percent; otologists 11 percent and Government agencies 5 percent. There are estimated to be some 2.3 million hearing aid wearers in this country, approximately half of whom are over the age of 65 years. Industry also estimates that there are slightly more than 7.5 million potential candidates for hearing aid use, at least half of whom, one may extrapolate, are eligible for the Medicare rolls.

If one assumes a conservative average suggested sale price of $300 per unit, excluding binaural fittings, this would result in an additional expenditure, by the public, of over $1 billion. By industry estimate, this expense would be repeated, on the average, every 3.4 years. Maintenance costs beyond the first, warranty, year and battery costs would be extra.

It has been estimated that New York State Medicaid has spent $2 million to provide hearing aids during this past year. At an average cost of $250 per unit, this amounts to 8,000 aids per year, solely under Medicaid. These figures become even more striking when one recounts Price Waterhouse statistics quoted (p. 97–98) for New York State at the last hearing aid hearings held by this subcommittee. Specifically, 32,000 to 35,000 hearings aids were sold by dealers at an average unit price of $250 to $275 (80 percent on no other advice than that of a hearing aid salesman). It is also estimated in 1968 that ". . . in New York State, almost 60,000 hearing impaired senior citizens over the age of 65 . . . 'cannot hear and understand spoken words' or 'can hear and understand a few spoken words'."

These statistics reflected essentially the first year of the Medicaid program in New York.

Prior to the advent of Medicaid (title XIX), hearing aids were subsidized under one of two Government programs, Vocational Rehabilitation (VRA) and Handicapped Children (Maternal and Child Health). Under these programs, hearing aids were recommended, subsequent to evaluation, by physicians and audiologists, supplied by the local retail dealer at a 20 percent discount to the Government. When the New York Medicaid program included hearing aids, essentially the same financial and referral arrangement prevailed. In 1972, New York took a rather dramatic step in limiting the reimbursement for the purchase of a hearing aid to a maximum of $235. Despite objections, the State had little difficulty in securing dealers to participate in the program.

With regard to Medicaid (title XVIII), as in 1968, neither hearing aids nor the necessary professional services to test for, evaluate and select hearing aids, as well as provide hearing aid rehabilitative services, are covered. Specifically (section 6120.7, Social Security Regulations) :

> "However, where the medical factors relating to an evaluation of appropriate medical or surgical treatment are already known by the physician and the diagnostic services are performed only for the purpose of determining the need for and/or the appropriate type or specifications of a hearing aid, the services would be excluded whether performed by a physician or nonphysician."

General diagnostic testing by a qualified audiologist when referred by a physician, is covered under section 6104.3 (see hearing transcript, 1968, pp. 217–218).

DISTRIBUTION SYSTEMS FOR HEARING AIDS

We have heard today, and will hear tomorrow, much of the "services" offered by the retail hearing aid dealer. Without attacking the general ethic of the hearing aid dealer, I wish to make a few observations. First, the purchase of a new hearing aid generally guarantees, at factory expense, 1 year of free contract service. Second, as an audiologist, comprising a portion of the 15 percent of 600,000 hearing aid referrals to dealers made by audiology clinics last year, I have no need of the so-called testing, evaluation, fitting, rehabilitation or counseling "services" offered by the dealer. These services ostensibly justify a large share of the suggested 200 percent retail markup in hearing aid prices to the consumer. As a professional audiologist, working with physician's referrals, I have only need of a hearing aid dispenser. That is, one who will carry an acceptable variety of brands and models of instruments, unfettered by franchise, quota or pricing limitations. He should be one who is able to fill accurately a hearing aid recommendation, make an earmold impression, fit the instrument, physically, to the patient's ear, provide basic operating instructions, reliable mechanical service to the instrument, in or out of warranty, and supply batteries and replacement parts as indicated.

As the audiologist is eminently qualified to provide all other hearing care service, after an initial physician's evaluation, there is no need for the patient referred by the audiologist to pay for dealer "services" which he purports to administer to the 69 percent of nonprofessional referrals to whom he sells hearing aids. Consequently, any distribution system which will follow clinical instructions reliably, deliver, fit and service the product to specification, doing so at a minimum expense to the consumer, will be eligible for my own professional hearing aid referrals.

The New York Medicaid "freeze" on hearing aid prices has produced a "spinoff" for patients of some centers who generate a significant volume of clinical hearing aid referrals. Specifically, a few dealers in the New York City area have agreed to provide hearing aids to clinic-referred, non-Medicaid patients at or near the limited New York State price of $235. Outside the New York area, where the cost of living is presumed lower, it has been reported that some larger clinics have been able to secure "clinic prices" for patients on the order of $200.

Within the last year or so, a new form of competitive, free enterprise, hearing aid distribution has developed. In contrast to the traditional "Edsel" system of low volume sales with high markup, high volume and low markup hearing aid sales operations have appeared. Dealing in hearing aids only on referral of a physician or audiologist, such operations as Master Plan, originally in Minneapolis, now in other States, Paid (Illinois) and Behavioral Prosthetics (Utah) deliver aids at average prices in the $150–$200 range.

For such hearing aid dealerships to succeed, they must have access to major brand suppliers at dealer quantity, factory wholesale prices. It is my understanding that pressures have been brought to bear by traditional hearing aid retailers against factories who sell to these plans, making it difficult to compete as in a fair, non-price-controlled market. The need for correct interpretation of FTC rulings, concerning exclusive franchising of dealers and factory suggested markup practices, is essential for this variety of American competitive free enterprise to prevail. In the last analysis, the hearing aid manufacturer can only benefit from the increased sales volume.

Personally discounting the idea of selling hearing aids as a professional audiologist, somewhat of a contradiction in terms, another alternative distribution system exists. This might be called the "hearing aid cooperative." A nonprofit or a limited profit corporation might be formed to serve the needs of all professional otologists and audiologists in the community who wish to refer their patients for hearing aids. If one analyzes the true average cost for the fitting of hearing aids by the Veteran's Administration, the feasibility, if necessary, of such a totally traditional-dealer-free system becomes quite evident. As the proportion of professional hearing aid referrals continues to rise, it would appear to be merely a matter of time before a "correction" in the distribution systems is a fait accompli!

RECOMMENDATIONS

(1) The FTC must vigorously pursue its cases to discourage the hearing aid industry from its limited distribution practices and its suggested retail pricing practices.

(2) With a physician's referral, professional audiologists should be permitted to offer their traditional hearing aid related services to the elderly hearing impaired individual under title XVIII (Medicare). These services, now proscribed, should include, but not necessarily be limited to, hearing evaluations, hearing aid selection and evaluation, counseling and hearing therapy.

(3) Brand name advertising of hearing aids, in other than hearing-related media, should be banned. Public relations programs such as the hearing aid industry's Better Hearing Institute might represent a more efficient pooling of capital resources to truly educate the hard-of-hearing to the issue of hearing health care.

(4) The Government must undertake a number of large scale demonstration projects to test several modes of hearing aid delivery systems compatible with the needs of the geriatric hearing impaired consumer.

ITEM 10. LETTER FROM ARAM GLORIG, M.D., DIRECTOR, THE CALLIER HEARING AND SPEECH CENTER, DALLAS TEX., TO ESTHER DANIELS; SUBMITTED BY MARVIN H. PIGG,* PRESIDENT, NATIONAL HEARING AID SOCIETY

DEAR ESTHER: The task of delivering otoaudiologic health care demands the use of a comprehensive health team. The most active and best suited members of this team are the otologist, the audiologist, and the hearing aid specialist. Each has his own position on the team but each must realize the task is best completed when the three members perform as a team. The task is too large and complex to be accomplished in any other way.

The problem of servicing the hearing impaired population in any country is accompanied by many difficulties because of the many varied disciplines necessary to provide adequate quality service to everyone. There is no need to enumerate these since they have been mentioned many times in many discussions.

It is glaringly evident that no single group can accomplish the task. As knowledge increases and improved identification techniques become more widespread the task becomes even more difficult and the answer becomes even more obvious. We must make use of everyone whether commercial or professional, who has any expertise in this field to organize a comprehensive health care team essential to servicing the communicatively impaired individual.

Traditionally the physician has been the responsible member of the health care community. As the need increased and the demand for health care service

*See statement, p. 52.

exceeded the service capacity and capability of the physician, nonmedical personnel began to appear. I use nonmedical only in the sense that the new team members are not trained in the classic medical techniques such as surgical intervention, drug therapy and diagnosis.

The M.D.'s training is primarily devoted to diagnosing and treating organic disorders. His expertise lies mainly in this aspect of health care. However, the need and demand for handling aberrant behavioral problems have become large during the past 25–30 years. To meet these demands the so-called paramedical professional has appeared. Examples are: clinical psychologists, speech pathologists and audiologists. A look at the history of these disciplines reveals that their original role was to test behavioral functions to provide means of comparison with so-called normal behavior in order to determine the need for application of behavior modification techniques directed toward correction of behavioral abnormalities.

It soon became apparent that the M.D. could not possibly devote the time necessary even if he were interested and capable. Consequently, servicing these patients went to the non-M.D. professional. Whether this occurred by delegation or default on the part of the physician is unimportant now.

In my opinion, we cannot possibly resolve the situation confronting us with respect to the hearing impaired individual without the complete cooperation of all groups and the recognition of the special knowledge possessed by each group. The hearing aid specialist has been subjected to much criticism during the past. He has been called many uncomplimentary names; but, if one looks at the history of medicine, the men trained in the last century, and even the early part of this century, were guilty of "growing pains" that were much more serious. In spite of the present attitude, many of the so-called professionals have for the hearing aid specialists, they are essential to the job ahead of us. For example, the doctor should not and, furthermore, does not want to handle hearing aids, the nonmedical professional, although he feels he is trained to do a better job of "fitting" hearing aids (whatever this means), cannot handle the servicing aspects of hearing aid wearing and maintenance as well as the hearing aid specialist. This means the hearing aid specialist is essential to deliver and maintain the aid. Obviously, this cannot be done properly without some special technical knowledge. It is our duty to see that this important member of the team be assisted to accomplish his role as a rightful member of the team. He is not the only offender in this very complex situation. The nonmedical professional is by no means less guilty of ignorance of his own place in the overall scheme. For example, audiologists are fairly evenly divided on the matter of "hearing aid fitting" techniques. There is serious talk of equipment to evaluate the patient's performance with amplification without using a hearing aid. Many audiologists use hearing aids as test instruments at present. These instruments are furnished by the hearing aid industry. In fact, the hearing aid industry keeps over a million dollars in aids at the disposal of many of the audiology centers. With present methods in use, it would be next to impossible for audiology centers to operate if the hearing aid industry refused to cooperate in this manner. In my opinion, trained audiologists should be evaluating people—not hearing aids. When the medical and nonmedical professionals are willing to accept the hearing aid specialist as a member of the team and work toward raising his level of knowledge, adequate to his duties, much better service could be offered the hearing impaired individuals, since there is not, and probably never will be, enough well-trained professionals to do the job. Criteria can be evolved that will assure top professional evaluation techniques for the cases that experience has shown need advanced training and counseling.

Our Nation is in a health crisis—a crisis marked by increased health expectations of a larger, better educated, and generally more affluent population. This crisis is manifested by inadequate services, which are themselves fragmented, inefficient, inequitably distributed, and uncoordinated. The crisis can be contained but only by national commitment to prompt action of a sweeping nature.

Health personnel are in short supply, inefficiently used, maldistributed, and specialized without regard to priority of need. Health facilities, which should be interrelated, are independently operated, unnecessarily duplicative, improperly distributed, uneconomically utilized, and often poorly managed. Health costs are inequitably distributed, rising faster than other costs, and are catastrophic for many.

Emphasis should be placed on restructuring the role of the health team members to assure that they play a positive leadership role in the rationalization of community and regional health services.

The shortage of professionals is expressed as a discrepancy between demand and supply of professional services. The capacity to supply services will be met only in part by an increase in the number of professionals. Of equal importance, and hopefully more immediately available, are organizational solutions to the problems of economy and effectiveness made possible by a reorganization of the delivery of health services. The final test of our educational programs, for all health professions and allied health occupations, is whether through them the health of the people is served to the fullest capacity of scientific knowledge and human dedication.

In the case of the nonprofessional, national and local associations should assume the responsibility of educating the nonprofessional to enable him to assume his rightful place in the otoaudiologic health care community.

Consumers have an obviously deep and primary interest in health services. The health professions alone cannot be the sufficient guardians of that interest. Consumers must have effective representation—wherever possible a majority—in the policymaking processes of major health facilities and organizations.

Accepting the fact that the consumer should be reckoned with in setting up health care delivery systems, professional and nonprofessional personnel must join to meet the needs of the consumer, in this case, the hearing impaired individual.

An examination of these needs indicates that they fall into three main categories: (1) The need for diagnosis, treatment, and/or rehabilitation, (2) the need for evaluation of performance, and (3) the need for correction by prostheses.

1. THE NEED FOR DIAGNOSIS AND TREATMENT

(a) Diagnosis and treatment should be strictly the responsibility of the physician. He is the only member of the otoaudiological team who is trained to recognize and correlate the "whole person" aspects of causal relations and efficacy of treatment of hearing impairment. Traditionally, by training and legal assignment of responsibility he should be the responsible agent for the otoaudiological care delivery system. The words diagnosis and treatment presume a red flag where physician and audiologist are concerned. I think this is more a semantic problem than a real one. Diagnosis implies a causal relation not only a location of defect in the auditory system. I have no objections to qualified audiologists telling me their tests indicate there is a problem in the middle ear, the cochlear of the retrocochlear system, but I do object to them telling me it is due to otosclerosis, etc., in the middle ear or noise or tumor, etc., in the sensorineural system. Much more knowledge of general body anatomy and physiology than is provided by audiological evaluation is essential before causal relations can be established and treatment can be prescribed. All of this is implied in the words diagnosis and treatment.

(b) Treatment and rehabilitation may take one or all of the following forms: Surgery; drug therapy; habilitation or rehabilitation, speech reading, auditory training, counseling, speech therapy, and amplification. The assignment of the various aspects of treatment should be a cooperative team effort. Classically surgical and drug therapy would be provided by the physician, while speech reading, auditory training, counseling and relevant speech therapy should be carried out by the audiologist and the actual application and maintenance of amplification is primarily the function of the hearing aid specialist.

2. THE NEED FOR EVALUATION OF PERFORMANCE

This aspect of otoaudiological care traditionally is assigned to the audiologist but the audiologist is not trained to handle the "whole person" aspect of performance. He is trained principally to determine abnormalities in performance due to faulty peripheral auditory sensory inputs and processing of these inputs. At present, audiological expertise is restricted primarily to evaluation of the end organ except for token attempts to evaluate neural trunk transmission, and no means at all to evaluate the information processing centers of the auditory system. When performance is considered from the "whole person" aspect it becomes obvious that a multidisciplinary approach is essential. Although the audiologist

is not capable of evaluating all aspects of performance, he is, when properly trained, capable of leading and organizing the "performance evaluation" members of the team.

It would be reasonable to say that the audiologist is prepared to, and should, provide behavioral information that will be used as part of the basis for determining eventual treatment and disposition.

As one well respected audiologist puts it, "The audiologist provides the 'software' for the physician to use, in consultation with the team members, to determine disposition."

3. THE NEED FOR CORRECTION BY PROSTHESES

The development and application of prosthetic devices requires much more knowledge than the professional "know-how" related to behavioral responses to amplification. Such responses can be determined in a limited way by tests performed by the audiologist under controlled conditions with high performance equipment. However, because hearing aids are by no means comparable to high performance equipment they are frequently used as test devices to determine the effects of the various performance characteristics most often found in hearing aids. The whole procedure is a time consuming, rather ineffectual technique. I have frequently called it a lot of "mumbo-jumbo." Its use began over 20 years ago and has not changed since. As a matter of fact, there is considerable doubt concerning its validity for several reasons which we will not discuss at this time.

This particular team function undoubtedly is the point of greatest contention, particularly between the professional and the nonprofessional. Initially the professional became involved with "fitting" hearing aids through the Army and Veterans Administration programs. Both of which were prepared to include pre- and post-counseling and hearing aid upkeep. As the demand for hearing aids increased it became obvious that many nonprofessionals were not prepared to handle the "fitting" needs required by many individuals. They were strictly oriented toward sales with little or no knowledge about evaluation of hearing aid performance. Because of this the professional felt the patient would be served better, if he handled the "fitting" and gave the nonprofessional specific instructions concerning which hearing aid should be given to the patient. Even if this arrangement had been acceptable to the hearing aid specialist it was not a satisfactory procedure since hearing aid acceptability is not necessarily related to real ear performance as measured with present day audiological techniques.

It would be rather ridiculous to say that the same system should be continued for the same reason now. Nonprofessionals of today cannot be compared with those of 10 years ago or even 5 years ago for that matter. The majority of present day nonprofessionals are substantial citizens with the desire, and in most cases, the knowledge gained through training and experience. Many are licensed by examination establishing them as capable of doing their part adequately. The national and State associations are pushing educational programs and establishing criteria for competency. When this group emerges from its growing pain period it will be a competent, essential, indispensable part of the otoaudiological health care delivery system. Professionals who criticize this nonprofessional group should consider their own growth and maturation periods.

The only member of this particular team who has reached full maturity is the physician, although at times he has not assumed his full responsibility. Neither the audiologist or the hearing aid specialist is fully matured. If we can say the audiologist supplies the "software" for the team then it will be logical to say the hearing aid specialist supplies the "hardware."

In summary the large numbers of the individuals who need otoaudiological care demands that a comprehensive delivery system be used. It demands the expertise of the physician, the audiologist and the hearing aid specialist. The task is much too difficult to be handled competently otherwise. Training and responsibility places the physician in the key position. The audiologist provides the performance evaluation and rehabilitation expertise and the hearing aid specialist the expertise in delivery and maintenance of prostheses.

Each member of the team must acknowledge each member's qualifications and work to produce a more efficient delivery system. The task is too large and demands too much of all of us to waste time and energy bickering and empire building. Such time would be better spent increasing our knowledge and pooling our efforts toward bettering the status of the impaired hearing individual.

This is rather lengthy but I felt the subject warranted a forceful, reasonably adequate discussion. I hope my stand is quite clear. I am rather annoyed at the "inter" and "intra" organizational in fighting directed strictly toward organizational and self preservation, with little or no thought about the individual who needs and deserves the best from all of us. Only comprehensive team care can satisfy his needs.

Thank you for the opportunity to comment.

Sincerely yours,

ARAM GLORIG, M.D.,
Director.

ITEM 11. THE NATIONAL HEARING AID SOCIETY'S PLAN FOR HEARING AID PROCUREMENT UNDER MEDICARE*

Hearing aids will be furnished to Medicare recipients under the following procedures: Potential candidates for hearing aids will be examined by an otolaryngologist certified by the American Board of Otolaryngology or eligible for certification. In cases where the services of an otolaryngologist are unavailable because of distance, or where this requirement would impose extreme hardship on the recipient, the recommendation of a physician in general practice is acceptable. The otolaryngologist or physician will make tests for diagnostic purposes, as defined by the advisory council to the State agency administering Medicare. If the patient shows any pathology that may be benefited by treatment, appropriate therapy to obtain recovery will be initiated. If the otolaryngologist in his diagnosis determines that audiological service is necessary he will so direct the client. When examination reveals no pathology, or after the completion of necessary therapy, and sufficient hearing loss remains, the patient will be considered a candidate for a hearing aid, and a letter so stating will be filed with the agency administering Medicare.

The hearing aid specialist of the client's choice shall perform tests necessary to obtain sufficient information for a hearing aid recommendation, as defined by the advisory council. The hearing aid specialist shall record all details of the test procedure and the results on a standard audiogram form in duplicate. In cases where a speech discrimination score is not obtainable, this information and the reasons therefor shall be noted on the audiogram form. One copy of this form shall remain on file with the hearing aid specialist, and the duplicate shall be forwarded to the State agency administering Medicare, with the make, model, and serial number of the hearing aid recommended, HAIC gain, and maximum output on recommended aid, ear to be fitted (or binaural) and the type of equipment used in speech testing.

The hearing aid specialist shall fabricate a custom ear insert for all air conduction instruments recommended, except in any case where the consulting physician states that an ear insert is contra-indicated on his report. The hearing aid specialist shall instruct recipients in the use and care of their hearing aid; arrangements shall be made for a maximum of five or more appointments within the first 6 months after the date of delivery, to assure the recipient the opportunity to discuss any problems and receive necessary assistance. The recipient shall be responsible to help complete these visits.

Hearing aid specialists shall be persons engaged in the testing, selection, fitting, selling, and servicing of hearing instruments, with offices established for that purpose which are separate facilities maintaining regular business hours. Hearing aid consultants are persons employed by the hearing aid specialists to fit, sell, and service hearing aids. Responsibility for the consultant's performance of duty lies with the hearing aid specialist. In those States with licensing for hearing aid dealers and fitters, all personnel testing for hearing aid recommendation, and selecting, fitting, and adapting hearing instruments shall be licensed under that State's hearing aid dealers and fitters act. In those States which are not licensed, the hearing aid specialist must have a

*See statement of National Hearing Aid Society, p. 52; see also appendix 3, p. 168.

minimum of 2 years experience with the selection and fitting of hearing instruments, and shall have conducted their businesses as prescribed by the code of ethics of the National Hearing Aid Society, the Hearing Aid Industry Conference, and the trade practice rules for the hearing aid industry of the Federal Trade Commission.

An advisory council consisting of three hearing aid specialists and three otolaryngologists shall be established to advise and assist in the administration of the program. They shall be responsible to the agency which administers Medicare.

After "authorization" has been cleared by the Medicare agency and the hearing aid has been delivered by the hearing aid specialist, payment will be made direct to the hearing aid specialist. Authorization from the Medicare agency is to be attached to the hearing aid specialist's billing.

We believe this is a workable program, which can be readily incorporated in the present Medicare program and we hope you will give it your serious consideration.

ITEM 12. MICHIGAN HEARING AID DEALER COST STUDY, SUBMITTED BY MARVIN H. PIGG,* PRESIDENT, NATIONAL HEARING AID SOCIETY

MEMORANDUM

To: Albert Lee, C.P.A., Auditor General.
From: Philip N. Dine, audit manager.
Date: July 18, 1972.
Subject: Hearing aid dealer cost study.

In response to a legislative request, we have performed a review, and compiled an analysis of hearing aid dealer sales and expenses for the 1971 calendar year. Our analysis is based on reviews conducted at 25 dealer businesses, which amounts to approximately 17 percent of the total dealer businesses in the State per Deparment of Licensing and Regulation's license report at July 7, 1971. The dealer businesses included in our review were selected on the basis of sales volume, of small, medium, and large dealers, and representation of various product lines. Most dealers that we contacted were very cooperative in providing us with access to their accounting records. However, we were unable to obtain access to the accounting records at three dealers originally included in our sample. In addition, we were unable to ascertain the necessary information from the financial records of another dealer due to the mix of hearing aid and other sales and expenses recorded in the accounts.

Sales, cost of sales and selling and administrative expenses were obtained from dealer financial reports or accounting records which we verified to Federal income tax returns. For some dealers, this information was obtained directly from tax returns and a review of paid vouchers, as other records were not available. Where possible, sales, cost of sales and selling and administrative expenses were obtained and compared for 3 calendar years ended December 1971. Selling and administrative expenses applicable to hearing aids were obtained by prorating total business selling and administrative expenses on the basis of the relationship between hearing aid unit sales and total sales. Partnership and corporate officers' salaries, FICA, and retirement plans were not included, as expenses for purposes of comparability with proprietorships.

Units sold were obtained by compiling sales invoices or, from manufacturers' reports of units purchased, or from commission sales report records which we verified to sales invoices on a test basis.

Our analysis of the 25 dealer businesses, totaling 5,813 hearing aid sales in the 1971 calendar year, disclosed that after deduction for commission and donations the average selling and administrative expenses amounts to $97.41 per hearing aid (see schedule A). The cost plus $125 sales price provided in the Michigan Department of Public Health providers agreement would amount to income of $27.59 per average sales unit.

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*See statement, p. 52.

SCHEDULE A

DEPARTMENT OF PUBLIC HEALTH, ANALYSIS OF HEARING AID DEALER AVERAGE SALES AND EXPENSES FOR THE 1971 TAX YEAR

	Analysis by dealer sales volume range			
	0–125 hearing aids	125–300 hearing aids	300-plus hearing aids	For 25 dealers
Average hearing aid sale price	$291.07	$332.47	$336.81	$329.63
Average hearing aid cost	[1] 125.30	127.30	129.84	127.29
Average gross profit per hearing aid	165.77	205.17	206.97	202.34
Average hearing aid selling and administrative expense	[2] 80.36	145.04	142.93	135.33
Less average commission and donation expense	.35	25.89	52.58	37.92
Average selling and administrative expenses before commissions and donations	80.01	119.15	90.35	97.41
Average net income per hearing aid before commissions and donations	85.76	86.02	116.62	104.93
Number of dealers tested	9	9	7	25

[1] Includes invoice cost of hearing aids plus batteries, ear mold, and components.
[2] Includes accounting, advertising, automobile, builidng and equipment rental, and depreciation, salaries, office expenses, commissions, taxes and licenses, interest, and other business expenses deductible for proprietorship Federal income tax reporting purposes.

SCHEDULE B

DEPARTMENT OF PUBLIC HEALTH ANALYSIS OF AVERAGE NET INCOME PER HEARING AID BASED ON AVERAGE SALES PRICE FOR THE 1971 TAX YEAR

	Dealer sales volume range					
	0–125 hearing aids		125–130 hearing aids		300 hearing aids	
Dealers average[1]	Low	High	Low	High	Low	High
Sales price	$274.00	$346.00	$292.12	$394.16	$325.35	$394.46
Cost[2]	134.65	137.86	118.58	129.35	122.75	116.50
Gross profit	139.35	208.14	173.54	264.81	202.60	277.96
Less selling and administrative expenses[3]	57.38	111.11	66.21	113.93	66.33	97.78
Net income per hearing aid	81.97	97.03	107.33	150.88	136.27	180.18
Number of dealers tested	9			9		7

[1] Of the dealers having the high and low average hearing aid sales price within sales volume ranges.
[2] Includes invoice cost of hearing aid, mold, and components.
[3] Commissions and donations excluded.

SCHEDULE C

DEPARTMENT OF PUBLIC HEALTH, ANALYSIS OF NET INCOME PER HEARING AID BASED ON ACTUAL SALES PRICES OF INVOICES EXAMINED FOR THE 1971 TAX YEAR

Dealer sales volume range	Actual sales price [1]	Actual cost [2]	Gross profit	Average selling and administrative expenses [3]	Net income (loss)
0 to 125	$473.00	$194.00	$279.00	$111.11	$167.89
	397.00	129.45	267.55	61.89	205.66
	369.00	186.00	183.00	98.76	84.24
	346.50	110.50	236.00	111.11	124.89
	340.00	149.80	190.20	57.38	132.82
	286.80	138.25	148.55	68.40	80.15
	275.00	88.37	186.63	61.89	124.74
	275.00	102.50	172.50	115.72	56.78
	250.00	85.00	165.00	115.72	49.28
	217.70	89.50	128.20	68.40	59.80
	213.00	106.00	107.00	68.40	38.60
	95.00	65.25	29.75	57.38	(27.63)
125 to 300	469.50	151.00	318.50	248.07	70.43
	389.00	159.00	230.00	79.95	150.05
	385.00	128.55	256.45	246.00	10.45
	371.00	149.00	222.00	79.95	142.05
	354.00	143.00	211.00	66.21	144.79
	349.50	124.95	224.55	71.58	152.97
	329.00	100.00	229.00	66.21	162.79
	324.00	143.00	181.00	79.95	101.05
	287.00	126.58	160.42	74.61	85.81
	187.00	98.50	88.50	74.61	13.89
	179.50	69.50	110.00	248.07	(138.07)
	125.00	76.00	49.00	246.00	(197.00)
300 plus	500.00	187.49	312.51	80.69	231.82
	425.00	128.50	296.50	66.33	230.17
	400.00	137.00	263.00	97.78	165.22
	398.00	168.65	229.35	150.91	78.44
	389.00	130.39	258.61	80.69	177.92
	387.00	120.00	267.00	72.42	194.58
	349.00	146.00	203.00	65.53	137.47
	345.00	146.00	199.00	150.91	48.09
	299.00	105.79	193.21	85.85	107.36
	257.00	81.00	176.00	72.42	103.58
	190.00	89.00	101.00	150.91	(49.91)
	189.00	74.50	114.50	80.69	33.81

[1] From high to low sales price on instruments sampled without regard to quality.
Includes invoice cost plus batteries, mold, and components.
[2] Commissions and donations excluded.

ITEM 13. LETTER FROM MARVIN H. PIGG,* PRESIDENT, NATIONAL HEARING AID SOCIETY, TO SENATOR FRANK CHURCH, DATED SEPTEMBER 13, 1973

DEAR SENATOR CHURCH: On behalf of the National Hearing Aid Society, I wish to express our appreciation for inviting us to present testimony at the hearings held by the subcommittee on consumer interests of the elderly on September 10 and 11. We feel that the hearings themselves are a valuable first step toward improving services for elderly Americans, and may well lead to programs which will materially improve their quality of life. We also wish to compliment you personally, your colleagues on the committee, and your staff for arranging hearings which were fair, and provided an opportunity for all viewpoints to be presented. You and your colleagues demonstrated great perception and insight into the issues.

I felt, however, that our spur-of-the-moment response to your question about our views on the Nader model licensing bill was inadequate, and that you deserve a better explanation. Perhaps this will offer clarification. We feel that the Nader bill is unsatisfactory for the following reasons:

(1) As you will observe when you study the bill, the way the definitions are written shows extreme partiality toward clinical audiologists. For them, there is a broad and comprehensive definition of role and function, whereas for otologists, otolaryngologists, and hearing aid dealers, the definitions are quite abbreviated. It is, after all, a hearing aid dealer licensing bill, and it is vital that the definitions be correct.

*See statement, p. 52.

(2) Under the bill, the board is given great power to regulate the practices of hearing aid dealers. Yet, only two hearing aid dealers are to be included on the nine member board. While we have always endorsed the principle of consumer representation on hearing aid dealer licensing boards, we believe that the major power must be vested in those sufficiently familiar with the occupation to make proper judgments. Peer group control is the mode in almost all, if not all, occupational licensing, and is a tested means of enforcing standards.

(3) The bill specified which facilities and equipment a hearing aid dealer must have, and includes a sound treated testing room. We feel that this should not be legislated. At this time, there is no agreement among the experts in the field that such a room is necessary or desirable. Special earphones can offer satisfactory attenuation of sound.

(4) The Nader bill would make a trial period mandatory by law. While many hearing aid specialists make trial periods available if their judgment indicates it is desirable in a particular case, our experience indicates that it does not always provide best management of the hearing loss. We feel that it is preferable to leave this decision to the judgment of those responsible for managing the hearing loss. Also, current FTC regulations require that any instrument which has had any use whatsoever cannot be sold as a new instrument, and must be clearly identified as "used." Since there is virtually a very limited market for used instruments, the hearing aid dealers are discouraged from offering trial periods.

This presents our views in summary of the bill available at the time of the hearings. However, I notice that today's mail included a sixth revision of the Nader bill, and, since I have not had a chance to study it, I don't know if changes have been made which would make it more acceptable to us.

I would be remiss in not using this letter to again thank you, your colleagues, and your staff for all the courtesies you showed me and the other NHAS representatives at the hearing.

Sincerely,

MARVIN H. PIGG, *President.*

ITEM 14. LETTER FROM MARVIN H. PIGG,* PRESIDENT, NATIONAL HEARING AID SOCIETY, TO SENATOR HIRAM FONG, DATED SEPTEMBER 13, 1973

DEAR SENATOR FONG: We appreciated the interest you demonstrated by attending the hearings held at the subcommittee on consumer interests of the elderly on September 10 and 11. We felt that your questions were quite astute, but felt that our anwsers may have been incomplete. Since you showed an interest in our certification program, I am enclosing a brochure which describes its requirements in detail.**

In addition, you may be interested in knowing that all retail hearing aid people, whether working toward certification or not, may take our basic course, the examination, and participate in the workshops, seminars, and annual meeting which stresses education. We also provide them with copies of our journal, Audecibel, which publishes current technical information about hearing aids and hearing loss. A complimentary copy is enclosed for your review.** Other publications are also available to them, as well as our members, such as consumer information pamphlets, reprints from Audecibel, and the book which we published, The Hearing Aid: Its Operation and Development, by Kenneth W. Berger, Ph. D. All of these, and more, are available to anyone, whether or not they are affiliated with our State chapters or the national society.

When a person chooses to meet our certification on requirements, as described in the brochure, he or she automatically becomes a member of the National Hearing Aid Society. We believe that the certification designation helps the public to readily identify the person as one who is competent and ethical. I think it would be a great thing if all who are in the field became certified. Also, as mentioned in our testimony, there are 38 States, including the State of Hawaii, that have licensing requirements to qualify all who enter the field.

I hope this provides the information you wanted. However, if I can be of further assistance, please contact me. And, again, thank you for the courtesy you extended us during the hearings.

Sincerely,

MARVIN H. PIGG, *President.*

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*See statement, p. 52.
**Retained in committee files.

ITEM 15. LETTER AND ENCLOSURES FROM ANTHONY DI ROCCO,* EXECUTIVE SECRETARY, NATIONAL HEARING AID SOCIETY, TO SENATOR FRANK CHURCH, DATED OCTOBER 4, 1973

DEAR SENATOR CHURCH: In conformity with the October 7 deadline for presenting materials for the record to supplement our testimony before the U.S. Senate Subcommittee on Consumer Interests of the Elderly, we are enclosing the following:

(1) Summary of the "answer to MPIRG." The MPIRG report was cited in the testimony of several witnesses.

(2) The NHAS analysis of the RPAG model bill, dated August 29, 1973, which is the most recent version we have received. The RPAG model bill was discussed at length in the RPAG testimony.

(3) The NHAS reply to the Consumer Reports article on "hearing aids," which was entered into the record by Senator Jennings Randolph.[1]

(4) A list of conditions requiring recommendation for medical examination as enacted in California and other states. A similar list is being incorporated into the NHAS model bill.

(5) The reply of the Maryland Hearing Aid Dealers Association to the RPAG Baltimore "study," which was a substantial part of the RPAG testimony.

(6) A letter from Maurice Schiff, M.D., attesting to the qualifications of hearing aid specialists and the effectiveness of the licensure law in California.

(7) A photocopy of a letter, which we are presenting for the record, from the NHAS legal counsel, Richard Kitch, responding to the questions raised in the letter of Richard Dowling [2] of the American Speech and Hearing Association. In his letter, Mr. Kitch documented the NHAS rights to the title, certified hearing aid audiologist. The original of this letter was forwarded to Mr. Oriol.

Due to the abbreviated deadline for submitting materials, we have been unable to include some items which we feel would provide additional assistance to you and your committee as you consider the question before you. These are:

(1) A reply to the RPAG report, "Paying Through the Ear." [3] Our copy of this voluminous report arrived just 2 days ago, and it is therefore impossible to read it and prepare an accurate evaluation in the allotted time. However, if this RPAG report or any substantial part of it, is to be included in the record of the hearings of your committee, we respectfully request that the National Hearing Aid Society be given an extension of time in order that our evaluation of it can be included in the record, too.[4]

(2) A map showing the geographical distribution of hearing aid specialists, which would visually describe their unique ability to serve the general population as presently distributed in the United States.

(3) A copy of the current model bill of the National Hearing Aid Society. This will be sent to you at a later date.

Please let me know if we can provide any additional assistance.

Sincerely,

ANTHONY DIROCCO, *Executive Secretary.*

Enclosures.

SUMMARY—THE ANSWER OF THE HEARING AID INDUSTRY OF MINNESOTA TO THE MPIRG REPORT

PREFACE

For purposes of clarification, the holder of a Ph. D. in audiology should not be confused with a medical doctor. Whether the audiologist holds a B.A., M.A., or Ph. D. degree, he is not medically authorized to treat, prescribe, operate, supply medication, or perform the functions of medical specialists.

INTRODUCTION

The hearing aid industry believes that the MPIRG report on hearing aids was intentionally biased to bring maximum discredit to the hearing aid industry in Minnesota and serve the interests of persons outside the industry.

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*See statement, p. 52.
[1] See part 2, appendix 2, item 4, p. 259.
[2] See appendix 2, item 2, p. 108.
[3] See appendix 1, item 2, p. 84.
[4] See appendix 2, item 16, p. 160.

MPIRG's report was inaccurate, biased and filled with unsupported generalities and subjective opinions which lead the reader to faulty assumptions and damaging conclusions affecting not only the hearing aid dealers in Minnesota, but the hearing aid users as well.

SURVEY

Physicians, audiologists, hearing aid dealers and even MPIRG all recognize that a hearing aid is an unwanted item. Those who do wear hearing aids may receive great benefit from them, but they are never totally satisfied, simply because a manmade hearing aid cannot be a perfect substitute for normal hearing. The same attitudes are apparent for all prosthetic devices.

Convinced that the survey cited in the MPIRG report was slanted and purposely biased, since the results contradicted scientific and objective studies conducted on a national scale, 21 members of the Minnesota Hearing Aid Society, a State association of hearing aid specialists, sent the identical MPIRG questionnaire to 4,100 hearing aid users, who were their clients. Each of the hearing aid specialists sent the MPIRG questionnaire with a covering letter. Of the 4,100 questionnaires mailed, 1,488 were returned, a 36-percent response. All returns were sent to a central post box for tabulating. The reports are on file and available for examination at the office of the Minnesota Hearing Aid Society.

In contrast to the results published by MPIRG, this survey showed that 75 percent of those fitted by hearing aid specialists were generally satisfied with their hearing aid. This high satisfaction level is particularly remarkable when one considers some of the factors making it impossible to achieve 100 percent satisfaction—lack of mechanical ability in operating the aid, insensitive fingers, low retentive memory for instructions, personal hearing limitations which no hearing aid can overcome, advanced age of the users, pride which prohibits wearing a hearing aid in public, areas where noise makes an aid ineffective, cases who, through delaying too long in securing help, have allowed hearing and hearing patterns to deteriorate, or new users unaccustomed to amplified sound and the use of a hearing aid. These factors explain why users are not totally satisfied with a hearing aid. Yet 92 percent expressed satisfaction with the services of their hearing aid specialist.

With regard to advertising, another item attacked in the MPIRG report, 70 percent of the respondents either favored hearing aid advertising, felt it was useful, or were indifferent to it.

These opinions obtained from those who actually use hearing aids are diametrically opposed to those obtained from the MPIRG survey, and its objectivity and validity become questionable. They sent the questionnaire to individuals in four highrise apartment buildings, and to the membership of the Minnesota Speech and Hearing Association, who have demonstrated antihearing aid bias on many occasions. The total number contacted was not furnished, nor was there any information supplied about the number of hearing aid users who were included. It is conceivable that none of their respondents had actually experienced the use of a hearing aid or the services of a hearing aid specialist. The Minneapolis Hearing Society, a nonprofit organization working with actual users and the hearing handicapped, provided the names of some 350 of its clients, who are consumers of hearing aid products, to be included in the survey. Yet, no mention of this group is included in the MPIRG report.

There was a marked contrast between the results of the MPIRG survey and that of surveys made by experts in opinion research. A national survey was conducted by Market Facts, Inc. using a representative sampling as shown in the Department of Health, Education, and Welfare report, "Characteristics of Persons with Impaired Hearing, United States" (June 1962–June 1963). The personnel of Market Facts, Inc. consists of unbiased, well-trained professionals of unimpeachable impartiality and Market Facts is without doubt far more accurate and scientifically sound in its surveys than the MPIRG report, which was prepared by untrained students. The Market Facts survey parallels the findings of the survey by the Minnesota dealers. The MPIRG survey does not reflect the opinion of the hearing aid consumers, but was designed to discredit the industry to enhance the position of other interests.

DELIVERY OF HEARING AID SERVICES

There appear to be two basic reasons why the hearing aid industry in Minnesota is under attack.

(1) The era of third-party payments, prepaid health insurance, and a national health care delivery system is growing in popularity. The battle lines are being drawn as to whom shall be designated as the proper, accredited provider of hearing tests, hearing aid evaluations, hearing aid fitting and hearing aid followup services to the hearing impaired.

(2) Hearing aid fitting and dispensing has been largely ignored by the audiological community until the last few years when there accrued a substantial reduction in Federal grants, many of which have been totally eliminated. In fear of being eliminated as providers by possible legislation, and because of diminishing supportive grants, especially in tax and grant supported centers which depend on such financial support to meet payrolls, the audiologists are now beginning to look elsewhere for another source or sources of income. There is an organized movement within and sanctioned by the American Speech and Hearing Association, the accrediting body of audiologists and speech pathologists, to dispense hearing aids "at cost" from the shelter of tax supported institutions, competing directly with the commercial sector of the market. Although hearing aid dealers do not oppose the entry of audiologists into the commercial sector, and their dispensing of hearing aids on a competitive basis, they oppose the dispensing of hearing aids by audiologists or anyone else from the shelter of a tax supported institution. Hearing aid dealers also oppose any audiologist who believes he has the responsibility or authority to define the responsibilities, duties, and functions of the hearing aid dealers.

The following points are vital and should be considered in evaluating the alternatives to the present system which are suggested by MPIRG:

(1) Less than 30 audiologists have the certificate of clinical competence in audiology in Minnesota, and many of these occupy research or teaching positions at universities or colleges. Some of these are not involved or interested in providing hearing aid evaluation services.

(2) On the other hand, best estimates indicate that there are approximately 75 established hearing aid offices and twice the number of hearing aid consultants located throughout the state of Minnesota to service the consumer.

(3) According to industry figures, approximately 16,000 hearing aids were sold and fitted in Minnesota last year. By conservative estimates, approximately 100,000 (and probably more) hearing aid users are currently in Minnesota.

These three facts present the following conclusions:

(1) It would be impossible for the few audiologists in the State to provide the amount, number and quality of services required to adequately care for the consumers in Minnesota who wear or will purchase a hearing aid. Major inconvenience which would result include the necessity for transportation to and from rural areas, costs of additional testing above and beyond the cost of the hearing aid, fees for followup services, and delays in obtaining appointment times for service.

(2) The presently constituted system provides the best geographic coverage as well as adequate numbers of personnel to provide necessary hearing aid services. Furthermore, the hearing aid dealers provide these services at no cost to the taxpayer and without support from governmental agencies.

MPIRG proposes, as an alternative, the purchase and equipping of "otomobiles" to service all the communities in the State. This is not feasible, for the cost of providing the vans and equipment, the number of vans needed to provide satisfactory coverage, the number of audiologists who would have to be hired, and the revenue necessary to administer such a program are prohibitive factors. Such a program would undoubtedly require extensive subsidies from local, State, and Federal moneys, whereas the same services are presently available from hearing aid dealers with no extra cost to the taxpayers.

LICENSING NEEDED FOR HEARING AID DEALERS

It is in the best interests of the hard of hearing citizens in Minnesota who need the help of a hearing aid to be fitted, delivered, and serviced by the men and women who have already been serving them with skill and compassion. The hearing aid industry in Minnesota supports, requests, and advocates the adoption of a licensing bill similar to those now enacted in 38 States across the country. Such licensing legally established the dealer's responsibilities and rights, and provides legal recourse for consumers. A licensing bill should not restrict the dealers' right to test hearing for the purpose of fitting hearing aids, to perform hearing aid evaluations, or to fit hearing aids.

This is the third consecutive legislative session in which hearing aid dealers in Minnesota, on their own initiative, have entered bills calling for the passage of a licensing law. These efforts have been defeated primarily with the help and through the efforts of some in the audiological community in this State.

DEALER SUCCESS IN FITTING

A professional market survey firm, Market Facts, Inc. conducted a program of research to evaluate how well the hearing aid industry is accomplishing its state purpose in rehabilitation of the hard of hearing. Their objectives were:

(1) To determine the overall levels of satisfaction expressed by hearing aid wearers.

(2) To determine the specific causes of dissatisfaction.

(3) To relate satisfaction levels to other experiences in terms of testing, fitting and other forms of service.

(4) To determine the attitudes of those who would be prospective wearers of amplification.

Market Facts was established in 1946 and has 250 employees. It is recognized as the largest company of its kind in the United States. Its officers are not permitted to be directors of any other companies. Its research is directed towards objective research design plus unencumbered commitment to accurate interpretations and forecasts.

The majority of Market Facts studies are for clients it has been serving continuously over the years and 47 of Advertising Age's list of top 100 advertisers are its clients as well as seven of the top 10 from Fortune's list of largest industrial corporations. In addition, it has done several studies for the U.S. Government.

In their study of the hearing aid industry, the sample tested was balanced on four demographic variables; age, income, population density and geographic region to match U.S. Census information, and thus represent as closely as possible a representative sample of U.S. households. In addition, a special selection of hard of hearing people both with and without hearing aids was screened out, and the sample compared to statistics published by the Department of Health, Education, and Welfare, to insure that the distribution of respondents closely matched Government population statistics.

The results indicated:

(1) Ninety-five percent of the respondents reported being either very satisfied or somewhat satisfied while being tested prior to purchase of a hearing aid, no matter whom they first consulted, whether it was a hearing aid dealer, audiologist, or physician.

(2) Similar findings were obtained (over 85 percent) when respondents were questioned about the service they received at the time of hearing aid delivery.

(3) The respondents indicated that their ability to hear with the hearing aid they purchased was equally good when purchased directly from the dealer (77 percent) as when they were seen by an audiologist (75 percent) prior to purchase.

Many more findings were reported, but essentially all of the results support the same conclusion: The hearing aid user population reported the exact opposite of the MPIRG contention that hearing aid dealers are unable to provide satisfactory, high quality hearing aid services to the consumer, and it refutes the contention that the audiologists are able to provide higher levels of hearing aid satisfaction than hearing aid dealers are.

Although the MPIRG report cites specific cases which they allege were improperly handled by hearing aid dealers, nowhere does the MPIRG report present an audiogram to substantiate their allegations. Nowhere is there a description of the environment in which the basic tests were conducted. The names of the audiologists and otologists who conducted their evaluations are not listed. Their claims, innuendos, and conclusions are therefore unsubstantiated. Even the quotes allegedly made from the conversations of hearing aid dealers were warped and reported in language calculated to make him appear nearly illiterate. Quite the contrary, a national survey made by the Hearing Dealer, May 1970, discloses that:

Sixty-six percent have some college training or were college graduates. Of this 66 percent: 2 percent held doctorate degrees, 3 percent held masters degrees, 25 percent were college graduates, 25 percent had completed 2–4 years of college, and 11 percent had completed 1 year of college.

To those who would suggest that 5 years of advanced audiological education and training is necessary for performing basic audiometry, we direct attention to the following facts:

(1) The Department of Health, Education, and Welfare, Division of Manpower Development and Training, in conjunction with the National Association of Hearing and Speech Agencies, has funded a nationwide program to train audiometric assistants. The program is designed for completion in 6 months, and, upon completion, each trainee is expected to be versatile and competent in the field of audiometry, that is, the measurement of hearing. The textbook used is called "audiometric assistant" and is a copy and compilation of the training manual used within the hearing aid industry.

(2) A series of articles have been published recently by the National Safety Council to inform and train health nurses, safety directors, and other nonmedical personnel in industry to perform basic pure tone testing. These articles, written by leading audiological authorities, indicate that adequate audiometry can be performed by well trained supportive personnel.

Most manufacturers maintain in one form or another either field training or in-factory training programs for hearing aid dealers and consultants. The industry has long supported, encouraged, and sponsored audiometric training for hearing aid dealers nationally. The National Hearing Aid Society, in conjunction with the Hearing Aid Industry Conference, has provided continuous upgrading in education and competence, which include seminars, workshops, conferences, and publications bringing a continuous flow of technical information.

The certification program sponsored and administered by the National Hearing Aid Society has been a significant and valuable effort in encouraging hearing aid specialists to reach and maintain high levels of competence in the selection and fitting of hearing aids. This was denigrated in the MPIRG report, which was incorrect in describing its requirements. Therefore, it is important that the requirements for Certification by the National Hearing Aid Society be outlined to correct the record.

Certification is granted only to those who have met strict standard of education, experience, competence and character.

Education.—The applicant must complete the NHAS basic course in hearing aid audiology, or an equivalent approved course.

Examination.—The applicant must pass the comprehensive NHAS certification examination, or an equivalent approved examination. All examinations must be monitored by a professional, i.e., educator, doctor, lawyer, etc.

Experience.—The applicant must submit proof of 2 years actual experience with supervision, in the fitting of hearing aids.

Endorsement.—The applicant must submit references from three persons; his employer, a physician (preferably an otologist), and a qualified person in the hearing aid field. The physician and employer affirm that the applicant is competent to make the required hearing analysis, take ear impressions, and adjust a hearing aid and earpiece to carry out their functions. The applicant must also submit character references, as well as financial references from his bank and suppliers. All references are thoroughly checked by the National Hearing Aid Society.

Ethics.—The applicant must pledge, under oath, to abide by the NHAS code of ethics. He muse also submit all his advertising for a period of 30 days prior to the examination, as proof of ethical advertising practices.

Evaluation.—On successful completion of these requirements, the applicant's name is published in a bulletin to the NHAS membership for comment. His application is then sent to the National Board for Certification for review and evaluation. All board members are certified members of NHAS, and come from various areas of the United States and Canada, to provide broad geographical distribution. Certification is granted only by majority approval of the Board.

In its by-laws, the National Hearing Aid Society has established a procedure for filing grievances against certified members, investigation of such complaints, and reprimanding any certified member who is found to have violated the standards. Penalties may be imposed, even to the extent of withdrawing certification.

COMPETENCE OF THE AUDIOLOGIST AS A HEARING AID EXPERT

The MPIRG report repeatedly suggests or implies that only the audiologist has the ability to recommend and fit hearing aids properly and that the level of

satisfaction will be greater if the audiologist rather than the hearing aid specialist fits the instrument. The Market Facts survey indicates that levels of consumer satisfaction are essentially equivalent for both the services of hearing aid specialists and audiologists.

Furthermore, the national audiological community is not agreed on the validity or the reliability of the techniques which are used in audiological facilities to predict or assess the performance with a hearing instrument.

The following quotation is from a recently published monograph, Hearing Aids, by Maurice Miller, Ph. D.

"These tests which comprise 'conventional' (audiological) hearing aid evaluation have been criticized by a number of audiologists as unreliable and unproductive in terms of the amount of time spent in performing them. In 1956, Miller and Spring retested the aid which yielded the 'best' and 'worst' results on the hearing evaluation. . . . In general, the authors found that the *initial results were not repeatable on subsequent testing. The aid which would have been recommended on the initial evaluation was frequently not the instrument of choice on the repeat test.* (Emphasis added.)

". . . The reliability of repeated measures in hearing aid evaluation was investigated by Shore, Bilger, and Hirsh (1960). Fifteen clinical patients with mild or moderate hearing losses were subjected to a series of clinical tests. . . . Shore, Bilger, and Hirsh concluded that the reliability of the three audiological measures used in their study was not good enough to warrant the investment of a large amount of clinical time in selecting hearing aids. . . . They further stated that *their conclusion implies that whatever the differences among conventional monaural aids might be, they are not detectable by these three audiometric measures.*" (Emphasis added.)

In another recently published text, Audiological Assessment (edited by a Minnesota audiologist from the Mayo Clinic, Darrell Rose, Ph. D.), the problem of objective, reliable testing for hearing aid selection and use is again discussed:

"One cannot question the desirability of objective audiological measures which will predict the degree of benefit a potential hearing aid user may expect from amplification. The problems involved, however, in developing such measurement procedures are immense. In addition to the problems of reliability of speech audiometry . . . *the following issues are among those which need to be resolved before we can, with greater confidence, predict how amplification will affect the listener's communicative behavior:* (Emphasis added.)

"1. Validity. Even if more reliable measures of hearing aid performance are developed for sound room use, we have no assurance that they will accurately predict performance outside the test room in the problem environments of everyday life.

"2. Short duration tests cannot reflect the adjustments to amplification that many hearing aid users seem to make with experience.

"3. Tests in noise suffer from the lack of resemblance between the test noises and noises encountered in everyday life. The development of valid noise stimuli is urgently needed. As a related issue, the influence of competing speech is not yet quantifiable in any practical manner.

"4. Speech stimuli presented in largely nonreverberant sound rooms differ significantly from speech as heard in hard-walled rooms such as offices, kitchens, schoolrooms and living rooms.

"5. Hearing aids used for clinical testing may differ in acoustical performance from the instrument of the same model which is ultimately delivered to the hearing aid buyer.

"6. The dynamics of psychological adjustment to amplification has not been well delineated or tested experimentally.

". . . (These problems) are far from being resolved at present. . . . *Until these and other vital questions are answered, the use of clinical hearing aid comparison procedures will doubtless remain a matter of individual conviction.*" (Emphasis added.)

A recently published letter in Asha, the Journal of the American Speech and Hearing Association, volume 15, No. 2, 1973, from a leading clinical and research audiologist, Gerald A. Studebaker, Ph. D., summarizes the problems effectively:

". . . An analysis of the current system makes it quite clear that the audiologist will never become expert in hearing aid evaluations because, under the stringencies of this system, he rarely has any idea of how his recommendations worked out, a situation rather analogous to shooting in the dark.

Hearing aid dealers continue as a viable force today because they more than make up for their relative lack of training with something even better, that is the sensible use of feedback from thir customers. (Emphasis added.) The principle is that you do again what worked and you don't do what didn't. Simple but effective.

"Audiologists complain that they don't want to 'fool with' all those little problems of the person with a new hearing aid. However, I believe that such complaints and problems represent the very feedback the audiologist needs to enable him to realize the full potential of his training. He is failing miserably in rehabilitation today because he is unwilling to receive these complaints for what they might be, that is, data that he can use to modify his future professional decision to the benefit of future patients."

ADVERTISING

Four years ago a study was reported from the speech and hearing clinic of Northwestern University which showed that approximately 30 percent of the clients who went voluntarily to the clinic for testing, and who were advised by that clinic to purchase an instrument, failed to follow through and do so within 2 years. (The national average is 5 years.) The hearing industry has observed over many years that hearing impaired people simply do not come forward to obtain hearing aids in the same manner as they do when they need other prosthetic devices. The MPIRG report recognized this problem.

The reason for this reluctance are complex and not completely understood, and occur throughout the world.

Hearing aid advertising is designed to motivate the hard of hearing to obtain care. Its intent is not to deceive or mislead, but is meant to motivate the hearing impaired consumer to take action. John Kojis, President of Maico Hearing Instruments, has said that the professionals have largely assigned this task to the commercial sector of the hearing health team.

In the distant past, some advertising may have been in bad taste. For this reason, in 1964, the industry set up a code of ethics for advertising, and established an ethics committee to monitor the industry's advertising. In addition, the FTC has provided a set of trade practice rules which govern and define what is acceptable and unacceptable.

It is unfortunate that those people who accept and laud improvements in hearing aids on the one hand, criticize and ridicule the hearing aid industry for advertising, on the other hand. Hearing aid advertising correlates directly with hearing aid product development, and industry alone has invested the millions of dollars necessary to carry out both functions.

PRICE OF HEARING AIDS

The MPIRG report devotes a great deal of space to the price of hearing aids. Using $100 as dealer cost for the average aid, and a selling price of $350, it leads the reader to believe that the difference between the two figures is all dealer profit. Such statements fail to recognize the marked difference between gross profit and net profit—a basic fact of commerce. Neither does it recognize the many items which consume the margin.

Among these items are: (1) Trade in allowances, (2) discounts to professionals, (3) discount of the price of an audiological workup if done, (4) office rent, (5) office salaries, (6) advertising, (7) free service calls to patients in rest homes, hospitals, or immobile patients in private homes, (8) time spent in counsel and instruction, (9) loss on bad debts, (10) mailing supplies and postage for returning repairs in and out of guarantee, (11) office furniture, fixtures, and equipment, (12) operating supplies, (13) instrument inventory, (14) public relations expense, (15) battery inventory, (16) contributions, (17) automobile expense, (18) telephone expense, (19) training expense for educational programs, (20) taxes—local, State, and Federal.

Price is relative and "profit" often misunderstood. As an example, an unground pair of contact lenses cost 47¢. It costs $3.50 to $4.50 to grind them to a prescription. Yet, contact lenses cost the consumer between $100 and $150. Yet, this margin is certainly not all profit. The cost of examination, fitting, test equipment, and many of the same costs experienced by hearing aid dealers consume a large portion of the difference between cost of the product and retail price.

An exhaustive and authoritative investigation of the hearing aid industry was conducted for the 1962 Kefauver report, covering the period from 1951 through 1960. Examination shows that there is only a slight difference between suggested retail prices of that era and those of today, despite increased costs in labor, materials, rent, advertising, travel expenses, and other overhead. Comparison of prices in 1973 versus those in the Consumer's Bulletin, January 1959, reflect the same small retail price increase again, despite ever-increasing costs.

A study made by Executive Reports based on statistics of the U.S. Department of Labor shows that hearing aid prices are being contained far better in general inflationary trends than many other health commodities:

	Percent of increase
Hospital daily service	246
Physicians fee	80
Dental expense	68
Eyeglass and personal care	45
Food and rent	35
Hearing aids	23

A study by the Hearing Dealer shows that the average hearing aid dealer earns between $10,000–$15,000 per year. Obviously, it is not a "get rich quick" occupation.

Too few persons outside the industry recognize that the mere supplying of a hearing aid is only the beginning. After-fitting service and counsel is usually a necessity. Service calls and home calls must be made, many times at hours when most businesses are closed. Ordinarily, there is no extra charge for either office visits or house calls. This is part of the delivery system.

The MPIRG report suggests that hearing aids can be sold at a lower markup than at present. This ignores the total cost of the services needed and supplied. As an example, to support their contention, the report refers to an outlet in Minneapolis which retails its instruments at approximately a 150 percent markup (erroneously reported by MPIRG as being a 40 percent markup). They do not mention that the outlet is supported and encouraged by certain members of the audiological community in the Twin Cities. As a consequence, it receives a majority of the clinical referrals in the metropolitan area, despite the fact that this outlet has only a very restricted selection of foreign hearing aids for sale. Here is an example of a sale from the MPIRG identified, so-called low price, low cost outlet:

A. Hearing aid cost to user:	
One CROS eyeglass hearing aid	$199
Attachment of temples	3
Cutting temples to fit	6
Recessing wires	25
Total	233
B. Additional cost to the user:	
Hearing testing and hearing aid evaluation by audiological clinic	44
Medical examination, referred by clinic	15
Total	59
C. Total cost to customer on delivery	292

The above figures do not include any charges for services which may occur during subsequent followup visits which could add further cost to the user. The cost to the dealer for this instrument is known to be $79, and as dispensed from this "low price" outlet, the markup is 350 percent to the customer. Furthermore, neither the "low price" outlet nor the Veteran's Administration provide the complete range of services now available from the hearing aid dealers. Neither does the "low price" outlet experience some of the costs incurred by a commercial outlet that does not enjoy such privileged referrals. It is of interest to note, too, that while the "low price" outlet dispenses a limited selection of imported instruments, many audiologists claim that they always select the best instrument from many brands, when in this case, price and other personal considerations (fees) dominate their referral decisions.

By and large, it is the dealer's de facto responsibility to use his talents and technique to keep the hearing aid in use after the fitting has been completed. In most communities, only the hearing aid dealer is in a position to pursue the after-fitting task in a fashion that is most likely to produce good results. He is the only member of the health care team who is willing and able to provide the necessary visits to the infirm, the shutin, to people in nursing homes and hospitals. Responsibilities and work styles of others in the hearing field usually are not geared to such outreach programs—and when they are, fees are charged, bringing the end cost to the user above that now charged by the hearing aid dealer.

ANALYSIS OF THE RETIRED PROFESSIONAL ACTION GROUP PROPOSED MODEL STATE LAW REGULATING THE FITTING AND SELLING OF HEARING AIDS

In general, the bill reflects a lack of familiarity with the hearing aid field, and is full of inconsistencies and ambiguities, which, rather than improving consumer protection, would create impediments to it, as well as create problems of compliance and enforcement. The RPAG bill transparently expands the role of clinical audiologists beyond that which is recognized and necessary, and paves the way for clinical audiologists to purvey hearing aids without adherence to the rules and consumer protection laws which govern the activities of hearing aid dealers, leaving consumers without protection in these circumstances. At the same time, the bill is unduly discriminatory, prejudicial, and punitive towards hearing aid dealers.

A discussion of the more pertinent points follows:

The definitions depart from the brief and clear language of the many hearing aid dealer licensing laws which are already enacted and proven. They substitute a patchwork of ambiguous phrases, difficult to interpret, with the intent of curtailing the essential activities of hearing aid dealers. A major purpose of any licensing legislation is to define the practices of that occupation being regulated by the law; it is more appropriate to define other occupations in their own regulatory laws. This is, after all, represented as a bill for licensing hearing aid dealers, and the very occupation being licensed is diminished by the definition, while there is aggrandizement of audiology.

Furthermore, the definition of "fitting" is unclear and confusing. For example, the phrases "taking audiograms," "making earmolds," and "assisting" in the selection of hearing aids, are inaccurate terms and contrast with the actual activities of hearing aid dealers in testing, taking impressions, selecting the hearing aid, and providing post-fitting services. If such activities are undertaken "for the sole purpose of the sale of a hearing aid," it would preclude services when the objective was other than making a sale. The definition provided by the RPAG bill omits any reference to required post-fitting activities, and would imply that a hearing aid dealer must discontinue services to his client after the sale is made. Neither does the definition state who is being "assisted" or to what extent, or who is responsible for the results.

The definition of "sale" or "selling" excludes "gifts by public or charitable organizations." Under this definition, charitable organizations could dispense hearing aids with totally untrained and unregulated personnel, much to the disadvantage of the most needy consumers.

The RPAG bill vests in a single Department (or, "as the context requires . . . the chief officer of the department and the duly authorized delegates of the chief officer") quasi-dictatorial powers which are dangerously broad and unrestrained, and without the customary checks and balances established in the American governmental system. The department both administers the law and appoints the advisory council members. Power is also vested in the department to conduct "such investigation as it deems appropriate," and this broad power does not afford adequate protection of civil liberties.

In addition, the bill establishes that the members of the regulated occupation are in the minority. This is an unsound and fallacious idea, not only from the viewpoint of the regulated group, but also the consumers, who would be poorly served if the majority of the advisory council have only limited knowledge, or no knowledge at all, of the business which is supposed to be regulated. The council's responsibilities, as defined by the bill, can only be fulfilled when judgments are based on specialized knowledge and experience in the field. This is why licensing boards, or advisory councils, of nearly all occupations, are manned by a majority of the members whom the bill regulates.

The intent of the exemptions provided by the bill are highly questionable. While the bill purports to establish "higher" qualifications for those who "fit" hearing aids, it exempts those who do so for educational or charitable institutions, and nonprofit or government agencies, audiologists, or physicians. While the physicians are only exempted if licensed, there is no regulation whatsoever for the others, in which case the consumers would have no legal recourse at all.

In addition, those who would sell hearing aids only upon the prescription of a medical ear specialist or an audiologist are also exempt. First, this implies that audiologists have the same qualifications as medical ear specialists, which is not the case. Second, since rendering a precise "prescription" for hearing aids is not possible at this time, the bill does not state who assumes the responsibility or liability if the "prescription" does not satisfactorily meet the needs of the client.

There is a question about the constitutionality and feasibility of requiring by law a medical examination and a written recommendation for a hearing aid by a physician or an audiologist prior to fitting a hearing aid. The National Hearing Aid Society believes in the advisability of medical examination for hearing loss, but prefers a more practical and feasible approach, which would accommodate the religious and personal convictions of some consumers, and provide all of them with maximum freedom of choice. Another important consideration is that the services of audiologists and medical ear specialists are practically unavailable in many parts of the country. Rather than make such examination and recommendation mandatory by law, it is preferable to include a list of conditions which are within the realm of the nonmedical specialty of hearing aid dealers to determine by interview and observation; when such conditions are identified by the hearing aid specialist, he would then be required to recommend to his client that a medical examination for his hearing loss be obtained. This list is incorporated into the present NHAS model bill, as well as many of the hearing aid dealer licensure laws which have already been enacted.

In many sections of the RPAG bill, there is recurring emphasis on the American Speech and Hearing Association as the arbiter of standards for an "audiologist." This is a highly questionable provision.

There is also an obvious attempt to restrict the use of the word "audiologist," or the term, "State registered." The National Hearing Aid Society holds the rights to the title, certified hearing aid audiologist, for use by its certified members, and their rights to this title must not be restricted by legislation. Furthermore, it seems unreasonable and even impossible, for a hearing aid dealer who is registered by the State to be prohibited from describing himself as "State registered," in order to comply with the law.

It is also unethical under this bill, for a hearing aid dealer to show or demonstrate a product which is "impractical" for the purpose represented. Under this bill, such items may even be a matter of recommendation. Who would decide when such an item may be shown or demonstrated, and how would this be decided? The RPAG bill is silent on these crucial questions.

The requirement that an adult person be present when fitting a hearing aid on an institutionalized person is sometimes advisable. But to assume that all of them need this is probably objectionable to most, since there are many reasons for institutional care other than mental incompetency.

Imposing a trial period by law is unprecedented, as far as we know, in the laws regulating any products or services. As stated here, it becomes an absurdity, since there is no statement defining what time period would constitute an adequate "trial." Whether a "trial" is desirable or feasible in individual cases should be left to the judgment of the hearing aid specialist, since experience has proven that "trial periods" for hearing aids may not always be in the best interests of the client.

In addition, it is undesirable to restrict the hearing aid specialists in making home calls. Through the years, the efforts of hearing aid specialists have helped significantly in identifying the hearing impaired and motivating them to obtain care.

Under the RPAG bill, a hearing aid dealer must furnish a receipt which:

(1) Must itemize all goods and services and the individual prices for them. This tends to eliminate a proven system and attempts to legislate a "fee-for-services" system. Many hearing aid specialists regard the "fee-for-services" system as a deterrent to those needing periodic attention in order to become successful hearing aid users. By including all services in the price of the hearing aids, the hearing aid specialists provide an incentive to their clients to obtain maximum care.

The receipt must also state ALL representations made about the benefits of the hearing aid, and written materials supporting such claims. This appears to be a deliberate obstruction of the dealers' activities, unknown in the regulations of any other health profession, and promulgated under the guise of consumer protection. When carried to its logical extremes, the receipt might need to include extensive literature which has been part of educational programs, and could assume ridiculous proportions.

The RPAG bill also requires a sound treated testing room as part of the equipment. At this time, the necessity has not been validated by research. The present standard requires that testing should be done in an environment "as quiet as possible," and exact standards are just now being studied and developed to determine how quiet is quiet enough. Most hearing tests done in the United States today are not conducted in soundproof rooms, but doctor's offices, schools, churches, industrial medical departments, and so forth. Even at this time alternatives to soundproof rooms are available with earphones having special sound attenuation characteristics. The research which is now in progress may lead to the development of other alternatives in the future.

In addition, a hearing aid specialist is prohibited from departing from the medical or audiological recommendations without consultation and written approval from the physician or audiologist involved. If the physicians and audiologists are to make the recommendations, it is questionable whether hearing aid dealers should be required to assume the responsibility and even liability for the results.

The application for renewal must show the current educational materials studied or the classes attended. The bill is silent about whether such study is a requirement for approval of the application. The bill states that no trainee certificate can be renewed if he has had an opportunity to take three consecutive exams. Yet, exams are scheduled at the discretion of the department, and conceivably, could be held so often that it would be impossible for a trainee to comply with the law.

The department is required to issue an order refusing to issue or renew, or to revoke or suspend the certificate of registration. It would also seem fair, if the evidence warrants it, that the department be required to dismiss charges.

The bill is silent regarding the action required of the council after it hears charges. If they are not empowered to do anything, the hearing may become only a meaningless exercise. The bill is also silent on other questions vital to insuring justice and due process, such as whether those charged are entitled to representation by legal counsel, or who should bear the costs for their defense. In general, although the penalties are severe, the rights of the defendants are not clearly defined.

The National Hearing Aid Society strongly favors the extension of educational opportunities for hearing aid specialists, and has been a leader in developing relevant educational programs. However, the procedures outlined in the RPAG bill are inappropriate, and allow two departments to interfere with the responsibilities of the governing bodies of public educational institutions, who, in most cases, are the elected representatives of the people. The explicit requirements of the program, as delineated in the RPAG bill, bypass the expertise of competent educators, and do not take feasibility into account.

NATIONAL HEARING AID SOCIETY,
Detroit, Mich., May 10, 1971.

MR. WALKER SANDBACH,
Executive Director, Consumers Union of United States, Inc.,
Mount Vernon, N.Y.

DEAR MR. SANDBACH: In many respects, Consumer Reports provides useful guidelines to consumers and frequently fulfills an urgent need for consumer information. Because of the good reputation of your publication, and the esteem accorded it by the public, I was concerned about misleading information which appeared in the May, 1971 article on "hearing aids." While parts of the article were factual, you appeared to misunderstand the role of the hearing aid dealers on the hearing health team—an important position which they have occupied for over 50 years. The National Hearing Aid Society put itself at your disposal for preparation of the article, and, if you had sought to consult with us, perhaps these biases could have been prevented. We would appreciate an opportunity to meet with your editorial board to discuss the matter.

One of the main themes of your article involved the costs of hearing aids. No one can deny that health care is expensive in these inflationary times, but to lay this problem at the doorstep of hearing aid dealers is grossly unfair. Like everyone else, the dealers do have a markup over manufacturers' price, necessitated by the services rendered. However, when you compare this with the costs of contact lenses, orthodontic braces, dentures, or orthopedic appliances, it helps put the question of costs in perspective. The manufacturing costs of any of these represent only a fraction of the cost of delivery. Surely you recognize that dealers, like other health services, have overhead and also must place a value on the services they perform. These services, contrary to your view, are considerable.

Numerous comprehensive health care programs are being developed to help people meet the costs of health care. I hope, along with many others, that in the future, some means can be found so that anyone in need of a hearing aid will be able to obtain it. Yet, so far, Government programs such as VA, if properly analyzed, have proven much more costly in the long run, and these costs are eventually borne by the taxpayers, already feeling overburdened.

Your suggestion that the cost of hearing aids could be lowered by decreasing the number of dealers would appear to have application in almost any marketing situation. Yet, antitrust laws seem to indicate that competition lowers prices, and not the reverse.

I would like to clarify for you the activities of hearing aid dealers with regard to services rendered. The services performed by dealers include testing, selecting and fitting the hearing aid, and extensive post-fitting care and counseling. If there has been a substantial hearing loss over a number of years, it is necessary to learn to hear again. Some people need counseling for several months when they start wearing a hearing aid. In practice, otologists and audiologists do not take this responsibility. Thus, after fitting, the client generally does not go back to them, and the hearing aid dealers assume total responsibility and personal liabiilty for wearer satisfaction, throughout the remaining years. He is the one who helps the client adjust to the use of the hearing aid.

You questioned dealer competence for these services when you stated that "The patient's difficulties in adjusting to a hearing aid should be eased by professional advice, not advice from a dealer." Actually, initial fittings and the post-fitting care has been an integral part of the dealers' services for over 50 years, and still are. Two major factors promote and assure dealer competence. First since 1951, the National Hearing Aid Society has had self-regulatory provisions; second, licensing of hearing aid dealers in 25 States has added Government controls. The NHAS standards are, at the very least, as stringent as the laws.

Hearing aid dealers are better trained than the audiologists to provide these services. Hearing aid dealers are specialists in this field, whereas the audiologists are not. Our certified members must have a minimum of 2 years practical experience under supervision, right on the job, and successful completion of the basic course in hearing aid audiology.

On the other hand, it is a verifiable fact that, regardless of other training, certified clinical audiologists have extremely limited experience in hearing aids. In the present state of technology in hearing aid dispensing, it is an art, not an exact science, and judgmental factors are an important consideration in successful fitting and adjustment to the hearing aid. The education and experience of hearing aid dealers qualify them better than the audiologists to make these decisions.

Also, there is a popular misconception that the audiologists have every conceivable kind of hearing aid available, and can choose the best from among them. This is quite an erroneous impression, and the public should be made aware of the limitations of hearing and speech centers. They do not offer the panacea popularly supposed.

I believe you recognized this when you mentioned the "bewildering profusion of aids on the market (500 or more)." But you seriously misstated the facts when you indicated that a "hearing aid dealer had little way of relating . . . specifications to his own wares." Hearing aid dealers have been testing and translating data to fit clients' needs for many years, and, as we stated previously, are more competent than the audiologists to make appropriate hearing aid fittings.

And this is fortunate for the public. Ultimately, any hearing aid purchaser must see a hearing aid dealer, since otologists and audiologists are prohibited from selling hearing aids. You might have offered the hard of hearing public reassurance by placing less stress on the rare incompetent dealer, and empha-

sizing the competence of the overwhelming majority. We all know that every field, including journalism, medicine, law and audiology, has its share of incompetents or unethical practitioners; by and large, however, we respect the qualifications and judgment of the majority. Let us accord hearing aid dealers the same respect.

I would like to add a few words about the hearing aid dealers and their relationship with other members of the hearing health team. You made the statement that "Otologists with whom we consulted in preparing this report commented that gross misfittings by dealers occur regularly." How many otologists did you consult? One, two, a dozen, a hundred, a thousand? Was this a representative sample? You leave the impression that otologists are generally dissatisfied with the activities of hearing aid dealers, but this is not true. Our dealers have enjoyed an excellent relationship with the otologists and make referrals to them for medical treatment. In some States, examination by an otologist prior to fitting a hearing aid is required by law, and our model licensing bill stipulates that a dealer must make this recommendation when dealing with a child.

As for the audiologists, you state that they are "generally critical" of hearing aid dealers. I have heard of a few individuals who were, but this is the first printed notification we have had of a group sentiment. We have had several meetings with their representatives, the national officers of ASHA, and had assumed that we met in the spirit of mutual cooperation. Perhaps, here again, as with the otologists, you did not consult with a representative group.

The biggest problem for all of us is to convince those in need of hearing aids to seek help. Resistance to wearing a hearing aid is common, for a number of complicated sociological and psychological, as well as economic reasons. The dealers alone offer the reassurance, comfort, and moral support to encourage and motivate the hard of hearing to wear hearing aids. The otologists and audiologists cannot provide this. As you pointed out in your statistics, 70 percent of the hearing aid users went directly to hearing aid dealers, which certainly testifies to the effectiveness of hearing aid dealers' efforts. Millions of experienced and satisfied hearing aid wearers provide an additional testimonial to dealer competence. It is apparent that without the services of hearing aid dealers, a much smaller percentage of the hard of hearing would avail themselves of proper hearing health care. Those who disparage hearing aid dealers simply do not have a clear understanding of the patience they exert, and their sincere and extraordinary efforts to act in good faith.

These are the facts which you need to know if you are truly concerned about care for the hard-of-hearing, and wish to help consumers with the selection of hearing aids. Perhaps, even at this date, you can find some means of clarifying these facts for the public. If you contemplate future articles about hearing aids, we ask the privilege of seeing the copy in advance, so that we can correct errors and biases before they are printed. Since yours is a reputable publication, and your credibility is at stake, I feel sure this would reflect your wishes too. In the future, as in the past, the information services of the National Hearing Aid Society will be available to you. Furthermore, our officers and I will be happy to meet with you at a time which would be mutually convenient.

Sincerely,

ANTHONY DI ROCCO, *Executive Secretary.*

CONDITIONS REQUIRING RECOMMENDATION FOR MEDICAL EXAMINATION

(FROM CALIFORNIA HEARING AID DEALERS LICENSING ACT)

These are similar to the provisions for medical clearance being incorporated into the model licensing bill of the National Hearing Aid Society.

3365.5. Whenever any of the following conditions are found to exist either from observations by the licensee or on the basis of information furnished by the prospective hearing aid user, a licensee shall, prior to fitting and selling a hearing aid to any individual, suggest to that individual in writing that his best interests would be served if he would consult a licensed physician specializing in diseases of the ear or if no such licensed physician is available in the community then to a duly licensed physician:

(1) Visible congenital or traumatic deformity of the ear.

(2) History of, or active drainage from the ear within the previous 90 days.

(3) History of sudden or rapidly progressive hearing loss within the previous 90 days.

(4) Acute or chronic dizziness.
(5) Unilateral hearing loss of sudden or recent onset within the previous 90 days.
(6) Significant air-bone gap (when generally acceptable standards have been established).

No such referral for medical opinion need be made by any licensee in the instance of replacement only of a hearing aid which has been lost or damaged beyond repair within one year of the date of purchase. A copy of the written recommendation shall be retained by the licensee for the period provided for in section 3366. A person receiving the written recommendation who elects to purchase a hearing aid shall sign a receipt for the same, and the receipt shall be kept with the other papers retained by the licensee for the period provided for in section 3366. Nothing in this section required to be performed by a licensee shall mean that the licensee is engaged in the diagnosis of illness or the practice of medicine or any other activity prohibited by the provisions of this code.

HEARING AID DEALERS ASSOCIATION OF MARYLAND, WASHINGTON, D.C., AND DELAWARE

Baltimore, June 8.—Millard Handelman, president, Hearing Aid Dealers Association of Maryland, Washington, D.C., and Delaware, today issued the following statement to the press:

By courtesy of the Maryland Board of Hearing Aid Examiners, we have reviewed the report of the Retired Professional Action Group (RPAG) which is to be included in Ralph Nader's forthcoming hearing disability study.

We were gratified to find the report confirmed our initial confidence, which was clearly and publicly stated, that the investigators must have been mistaken—to say the least—about the alleged misdeeds of Baltimore hearing aid dealers. Even on the RPAG's own findings, as a group the 15 dealers visited by a team of eight elderly investigators, all using aliases, emerge from the report as upright, conscientious, competent businessmen.

A few of the cases, as reported by the public relations woman who headed the clandestine investigating team, are quite muddled and confusing: We need more information to form an opinion of the performance of dealers in question.

The Maryland licensing board already has taken prompt action. As soon as the Nader publicity was released, the board requested additional information and held a special board meeting to review the report. Today we have been further assured that each case is being examined. Appropriate action will be taken on each case based on the merits, and the disposition of all cases will be made public, the chairman told me yesterday.

This is the responsible way to hear and adjudicate an adversary matter. The method of trial and conviction by headline, condemning a whole class of businessmen or other individuals, is contemptible. It is a vicious shotgun technique instead of a constructive effort to correct inadequacies in the marketplace on a specific basis.

Nor are only a limited group of businessmen being hurt in their professional pride, personal reputation, and income. The much broader disservice is to the tremendous number of hearing impaired persons, already too reluctant to seek the help they need to alleviate their affliction. For a reckless, careless, biased report such as this must shake if not shatter the confidence of those handicapped persons who stand most to benefit from the services of a reliable, competent hearing aid dealer. By which I mean the vast majority of hearing aid dealers.

We of the tri-State association have analyzed the report, with no further knowledge of what actually happened in the cases described in the report's capsule summaries. The total effect of these thumbnail summaries amounts to a reversal of the RPAG's charges that Baltimore dealers are incompetent and/or unethical.

We found that at least 85 percent of the cases, even as sketchily given in the Baltimore report, show that the dealers involved performed ethically, conscientiously, and competently.

The investigators and the Nader activists, in their ignorance of the whole hearing picture as well as the role and responsibility of the hearing aid dealer, thought they were labeling these dealers as crooks and/or incompetents. Ironically, their preconceptions were disproved by the facts and the outcome is the reverse of what they expected.

As for "high-frequency losses," there is a fact gap exposed in the report.

We in the hearing aid field know that different people have different purposes in mind for their hearing aid use, just as they have different types and degrees of hearing loss. The dealer must assume that people come to him to find out whether a hearing aid would be helpful. If the client tries the aid and finds it likely to be useful, the dealer should certainly be willing to sell the aid, even if it is to have use only under certain conditions—such as in church, in business conferences, lectures, etc. This is particularly true in the case of high-frequency losses.

Or take the cases of investigators claiming to have been "high pressured" by a dealer. This is of course a subjective judgment, unsupported by witnesses, and out of the mouths of persons whose avowed and voluntary mission was to build a case against as many dealers as possible, for the Nader report. If a dealer discovers that a client will benefit substantially by using a hearing aid he certainly is going to urge the client to be fitted.

One female investigator reported—as though it were a fault—that the dealer preferred to discuss a hearing aid in the presence of her adult son. It is a common and very sensible practice, particularly when the client is elderly, to bring other family members into a discussion involving a purchase which is not only a comparatively major one for most incomes, but more importantly, a step typically requiring deep personal understanding between the dealer, client, and members of the family.

The report notes that several dealers urged the clients to wear a hearing aid on a trial basis for a while. What could be more fair than that? The wearer gets a chance to see how well the aid helps his hearing, and to decide whether he wants to spend the money. Those dealers who ask to test the client at home are giving the client an opportunity to try their hearing aid under actual real-life conditions.

What most people outside the hearing aid business don't seem to understand is that the dealer's function is not to diagnose their hearing but to try to find out if the client's particular loss is the kind that will benefit from amplification, and to fit the client with the right kind of hearing aid to provide the needed amplification.

Time magazine says Ralph Nader's forthcoming hearing disability study will be "searing." If the Baltimore caper is an indication of the tone and reliability of the national study, then the entire population of hearing-impaired persons—at least 14 million, and most of them elderly—will be disastrously hurt along with the 6,000 hearing aid dealers who are their main hope for better hearing.

LA JOLLA, CALIF., *September 7, 1973.*

Miss ESTHER DANIEL,
Washington, D.C.

DEAR MISS DANIEL: Services rendered by competent dispensers are highly beneficial to the hard of hearing public. No other hearing aid delivery service has the capacity to reach out to the public with equal facility and efficiency.

Historically, it has been through the constant advertisements and information to the general public, that many patients have been made aware of their hearing loss. This advertising now is ethical and factual in the State of California. By the laws and regulations embodied in the business and professions code, and implemented by the California Hearing Aid Dispensers Examining Committee, the education, supervision, and regulation of the hearing aid dispenser has been greatly improved and now functions efficiently and ethically within this state.

Similar regulatory committees now exist in California for the speech pathologist and audiologist, optometrist and optician, building contractor, and automotive mechanic. All of these are under the excellent supervision of the Department of Consumer Affairs.

Complaints now have legal redress by the energetic director and committee chairpersons. As a result of this, complaints are now handled judiciously and equitably to the end that the consumer is well served and protected.

To remove the hearing aid dispenser would be a service disaster. Nowhere else is there a pool of trained or regulated personnel, to serve the widely dispersed, frequently confined, and remotely located hearing aid user.

I, therefore, strongly urge that hearing aid dispensers not be eliminated from any program developed for the fitting and selling of hearing aids.

MAURICE SCHIFF, M.D.,
Member, Hearing Aid Dispensers Examining Committee.

KITCH & SUHRHEINRICH, P.C.,
Detroit, Mich., October 3, 1973.

Re National Hearing Aid Society's response to Richard Dowling.

Mr. WILLIAM E. ORIOL,
Staff Director, Special Committee on Aging,
Washington, D.C.

DEAR MR. ORIOL: It is my understanding that you forwarded to the National Hearing Aid Society a copy of Mr. Richard J. Dowling's (director of governmental affairs for the American Speech and Hearing Association) letter of August 30, 1973 and requested comments thereon.

Inasmuch as the letter makes reference to a great degree to legal matters, namely the National Hearing Aid Society's collective membership mark encompassing the title "certified hearing aid audiologist," the letter has been referred to me as legal counsel for the National Hearing Aid Society for response.

Originally, I had intended to make only a short reply to this letter, but the more that I reviewed the deceiving manner in which it was constructed, the more I realized that the time had come for a full and frank rebuttal to letters of this kind which constitute a part of a well programmed attack upon the Nation's hearing aid dealers. It is obvious that I am not a hearing aid dealer, but am a lawyer. I have, however, as a result of my representation of the National Hearing Aid Society determined that it is, in fact, not only an entity providing a unified voice for the Nation's hearing aid dealers, but is an organization truly dedicated to assisting the hearing impaired. It is an organization of competent, ethical hearing aid dealers and I am exasperated at the fact that its work (and as a result, full benefit to the hearing impaired) is impaired by uncalled for scurrilous attacks by a few zealous individuals operating on the basis of improper motivation.

Investigation will reveal that representation of the National Hearing Aid Society constitutes a very small portion of my practice and I have no incentive to write the following, other than to bring the truth to the fore.

For the most part, the hearing impaired team of physicians, hearing aid dealers, and clinical audiologists work harmoniously with one another. Obviously, such a situation provides the best atmosphere and climate for the assistance of the hearing impaired. A small segment of clinical audiologists have for years sniped at the hearing aid dealers, contending that all dealers are incompetent and corrupt. Such attacks have intensified in recent years for several different reasons. These clinical audiologists have found a ready ally in the various consumer protection groups who have been shown to be prone to accept all allegations of incompetency and unscrupulousness made against anyone, without the necessity of competent supporting evidence. I am certain that there are a number of factors motivating this small vitriolic group of clinical audiologists, but the two which are most obvious have nothing to do with any ultraistic ideals relating to truly assisting the hearing impaired. These are: (1), ego; and (2), greed.

(1) Those few clinical audiologists involved in the continued harassment of hearing aid dealers represent a perfect example of the adage "A little knowledge can be a dangerous thing." These clinical audiologists believe that since they have certain university training, that they are the sole individuals capable enough to render competent assistance to those suffering a hearing loss. Apparently their egos require that they constantly belittle everyone else connected with the hearing impaired, in order that they may at least in their own minds maintain a self image of superiority. I am sure that you will recall that at the recent hearing of the Committee on Aging, the clinical audiologist working with the Nader group, in questioning by Senator Fong relative to the provisions of the Nader group's proposed licensing bill for hearing aid dealers containing a requirement that a prescription be obtained from either a doctor of a specified specialty, or an audiologist, before anyone could purchase a hearing aid, attacked even the competency of a doctor of medicine (not board-certified in otolaryngology or otology) to diagnose hearing loss, or to write a correct prescription with respect to a hearing loss. I have recently had direct involvement in a matter where a clinical audiologist made condemning statements to a patient that the patient's otolaryngologist was ill-equipped to diagnose hearing loss. In essence, these people are saying that the entire handling of the hearing impaired (save for matters involving surgery) should be left to them since all others involved in this endeavor are incompetent.

(2) Though never mentioned, these individuals dedicated to the continued demeaning of hearing aid dealers have a direct financial interest in destroying and eliminating the hearing aid dealer. For several years, this same small group has been attempting to convince the members of the American Speech and Hearing Association that the code of ethics of the American Speech and Hearing Association should be amended to authorize the sale of hearing aids by clinical audiologists. This proposal is before the American Speech and Hearing Association membership at their annual meeting being conducted at this very time. It is mistakenly believed by this group that the sale of hearing aids is highly lucrative and that they want badly to get in on the "spoils." That should they be "authorized" by ASHA to sell hearing aids, these individuals would like nothing better than to enter into this endeavor with no effective competition present. The elimination of the hearing aid dealer from the scene would leave to these few clinical audiologists who desire to sell hearing aids a virtual monopoly. It is for this reason that the attack on hearing aid dealers has been so intensified.

Hearing aid dealers are at the present time unable to make use of the powers of the Federal Trade Commission, inasmuch as this activity, which clearly consists of an attempt to restrain trade, is being carried on by those who are not, as yet, competing with the hearing aid dealer.

Mr. Dowling's letter to you of August 30, 1973, is just one part of the program being carried out over the entire United States in an effort to totally eliminate the hearing aid dealer.

As to the title "certified hearing aid audiologist," the National Hearing Aid Society, does, in fact, have a collective membership mark incorporating the term "certified hearing aid audiologist" registered with the U.S. Patent Office (Principal Register No. 884,377). Even without such a register, the hearing aid dealers of the United States would, by virtue of their common law rights, be entitled to the sole and exclusive use of the term certified hearing aid audiologist since it was a hearing aid dealer who coined and first used the term audiologist. Review of historical evidence supports this fact. Examination of the textbook "Telephonics Primer and Fitting Manual, Number 28" coauthored in 1939 by Mr. Stanley Nowak, a pioneer in the sale and distribution of hearing aids, reflects the term audiologist to have been repeatedly used to designate those individuals involved in the selection, fitting, and selling of hearing aids. Andy B. Harvey, a pioneer hearing aid dealer, used the term audiologist as early as 1940 to describe the nature of his services. In the 1950's the term audiologist was closely associated with hearing aid dealers throughout Europe as well as within the United States. An early organization of hearing aid dealers, the International Hearing Aid Association, formulated plans for a certification program for hearing aid dealers and in the 1940's proposed that members so certified would be known as "certified hearing aid audiologists."

Those who later came into the hearing impaired scene and adopted the term "audiologist" were, in fact, infringing upon the title already being used by hearing aid dealers. Inasmuch as these individuals were careful to delineate themselves as clinical audiologists and research audiologists, as opposed to hearing aid audiologists, the hearing aid dealers did not become concerned that the public would be misled by this development. The use of the term "certified hearing aid audiologist" is carefully supervised and controlled by the National Hearing Aid Society and any misuse is immediately challenged. Certified members of the National Hearing Aid Society do not designate themselves as "audiologists," or "hearing audiologists." They are proud to be identified as "hearing aid audiologists" and contrary to Mr. Dowling's statements, the title is never used in any manner to deceive the public, but is used to make it clear to all the specific area in which the dealers are involved with audiology.

Mr. Dowling fully recognizes that hearing aid dealers are legally and legitimately entitled under the common law and by Federal statute to use the term "certified hearing aid audiologist" and that they make only proper use of that title.

His letter to you, suggesting that the Committee on Aging undertake in some manner to override and abrogate the hearing aid dealers' common law and statutory rights, is a reflection that Mr. Dowling is aware that such a challenge, if made directly by ASHA in a due process manner, would be rejected. Mr. Dowling's comments, intended to create the impression that the title "certified hearing aid audiologist" is conferred without proper circumspection by the National Hearing Aid Society, represent an insult to the intelligence of the members of this committee. It is a matter of record for many years that the comments

made are incorrect. The requirements for certification in the National Hearing Aid Society have been publicly spelled out on so many occasions (See: 1968 record of proceedings for Committee on Aging relating to hearing aids), that it can only be assumed that Mr. Dowling's misstatements as to same are a deliberate intentional attempt to deceive and mislead this committee.

The true facts are that to become a certified hearing aid audiologist, a dealer must demonstrate that he has 2 years' experience in fitting and selling hearing aids; that his application for certification must bear the endorsement of a physician practicing in his community and of two certified hearing aid audiologists; he must take a course of instruction which relates, in part, to the anatomy of the ear, hearing loss, the testing of hearing, and the fitting of hearing aids (prepared, in part, by audiologists) and which requires the reading and reference to three textbooks recognized as authoritative in the field of audiology; he must pass an examination closely monitored (the monitoring is ever being revised to eliminate any question of credibility); and even should an applicant complete all of the aforementioned requirements, certification will be withheld until it can be clearly demonstrated that he has and will live up to the ethical standards reflected in the code of ethics of the National Hearing Aid Society (which parallel the regulations of the Federal Trade Commission for the hearing industry).

Mr. Dowling's suggestion that a prospective purchaser of a hearing aid be required to first obtain a prescription for same from a physician or clinical audiologist encompasses the basic premise that the hearing impaired are also mentally impaired and thereby lack the capacity to make proper judgments regarding who they deem it necessary to see regarding their hearing problems. I would ask Mr. Dowling if he believes Senator Percy, a member of this committee and a wearer of a hearing aid, fitted by a hearing aid dealer, is so mentally retarded that he should not be allowed to make his own choice with respect to the manner of improving his loss. Would he require Senator Percy to see a clinical audiologist every time the Senator decided to purchase a hearing aid?

The suggestion of mandatory prescriptions is sometimes limited to persons over 65 years of age, but it has no more validity with this alteration. The U.S. Senate and U.S. House of Representatives have many members who are over 65 years of age. These Congressmen function fully in handling the legislative needs of the United States. Would those who propose such a requirement suggest that these distinguished gentlemen are so senile, or lack such mental capacity, that they are incapable of correctly determining how or where any hearing problem they may encounter should be handled? In this country, every person not declared legally incompetent has a constitutionally guaranteed right to make his or her own decisions to do what they will with their own bodies. The suggestion of Mr. Dowling is not consistent with this constitutional right.

I recognize that this letter is lengthy, but I see no other way to put into proper perspective the misleading and deceptive information contained in Mr. Dowling's letter.

I thank you, individually, and on behalf of the National Hearing Aid Society, for the opportunity to respond to this letter and I will hold myself available to provide you with any further information or assistance that you may desire.

Yours very truly,

RICHARD A. KITCH.

ITEM 16. LETTER FROM ANTHONY DI ROCCO,* EXECUTIVE SECRETARY, NATIONAL HEARING AID SOCIETY, TO WILLIAM E. ORIOL, STAFF DIRECTOR, COMMITTEE ON AGING; SUBMITTING REPLY TO RPAG SUMMARY REPORT, DATED NOVEMBER 9, 1973**

DEAR MR. ORIOL: As you requested, we have prepared the enclosed reply to the RPAG "summary" of their report. We have already commented on many parts of it, and have so indicated in this statement. We have been brief, so not to burden you with a volume of incidental comment. At the same time, however, we want to provide as much information as is necessary to set the record straight and give your Committee a full view of the hearing aid delivery system as it actually is. We hope we have succeeded in steering a middle course. However, if there are any other areas where you feel further information would be desirable for your study, please do not hesitate to contact me.

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*See statement, p. 52.
**For summary of RPAG study, see appendix 1, p. 84.

Thank you for all the consideration you have shown. We cannot help but feel that your efforts, and those of your staff and the Senate Committee have contributed significantly toward producing a truly fair and impartial study. That is certainly our objective, and we believe it is yours, also.

Sincerely,

ANTHONY DI ROCCO, *Executive Secretary.*

Enclosure.

THE REPLY OF THE NATIONAL HEARING AID SOCIETY TO THE RPAG "SUMMARY" OF PAYING THROUGH THE EAR, SUBMITTED TO THE U.S. SENATE, SPECIAL COMMITTEE ON AGING

Actually, the RPAG summary which was submitted to the National Hearing Aid Society for comment is not a summary of the report, Paying Through the Ear, but interjects numerous extraneous elements in response to testimony of the hearing aid industry at the Senate hearings, September 10–11, and omits some elements of the original report which deserve comment. Therefore, for the sake of brevity in the following analysis, the National Hearing Aid Society is responding only to the "summary," and not the report itself. However, should the complete RPAG report become a part of the record, the National Hearing Aid Society would appreciate an opportunity to make a detailed reply.

COMMENTS ON THE OVERALL "RPAG SUMMARY"

The RPAG "summary" introduces some odd problems in logic. When these are examined it appears that RPAG has made selective use of facts and inferential leaps to arrive at unwarranted conclusions.

For example, the industry is criticized for not making sufficient effort to broaden the market, while, in other sections, the industry's public education and advertising programs are also criticized. Yet, nowhere in the report do they outline an alternative outreach program which they feel would be more beneficial to consumers.

To support their condemnation of the industry, they say that "the number of hard of hearing people in society is increasing, so that, to be meaningful, the number of units sold must be expressed as a percentage of the number of hearing impaired people as compared to previous years." This is specious reasoning, for this would give a misleading statistic, which does not account for the increasing number of hearing impaired who are being treated medically and surgically, making a hearing aid unnecessary. The oversimplification which the RPAG report recommends would not be an accurate measure of the service which is being provided by the industry.

By ignoring the benefits of medical and surgical care in this statistic, the RPAG has illogically ignored one of their own major recommendations—greater involvement of the medical profession in management of hearing loss. Therefore, it becomes difficult to follow their reasoning.

Similar problems of logic are reflected in the letter from the consumer of hearing health care to the Indiana State Board of Health. First, this must be regarded only as the opinion of one single layman. Second, it should be pointed out that this person did, indeed, have medical advice prior to the purchase of a hearing aid, and this respected and admired medical doctor had recommended that he see a hearing aid specialist. The hearing aid which the specialist fitted apparently was very beneficial. But, by his own admission, the author of this letter had no knowledge of hearing tests, but nevertheless relates in technical terms what he thought he heard the hearing aid specialist tell him. Since the consumer says he had no knowledge of the matter, it is questionable whether he is indeed qualified to quote the hearing aid specialist's evaluation accurately. However, the strangest shift in logic occurs when he discusses the great help he received from a medical specialist, and then concludes that an audiological examination should be required before a hearing aid can be sold. Audiologists are nonmedical specialists, and under no circumstances are they trained to diagnose, treat, or perform surgery. These are proper activities only for members of the medical profession. We believe this shift in logic which promotes the profession of audiology is further evidence of the attempt made in the RPAG report to expand and enhance that profession.

This consumer's fear that his hearing may become further impaired because of "infections from the hearing aid" is evidence of the unnecessary apprehension suffered by the hearing impaired regarding the use of a hearing aid. The hearing

aid industry has made a monumental effort to alleviate such apprehension, and remove the mystery from hearing aids, but their efforts are being stymied by such invalid, inaccurate, and illogical reports as the RPAG has made. The fears of the hearing impaired are greatly magnified when a group such as RPAG plays on these fears by presenting unsubstantiated opinion in the name of research.

The RPAG "summary" also presents other unsupported conclusions. They quote Dr. Charles Giffin, an otolaryngologist, who recommends that a medical examination be obtained for a hearing loss. In this statement, he questions the validity of hearing aid dealers' tests, an opinion which is far from universal. (See letter by Maurice Schiff, M.D., to our Vice President, Esther Daniel*). However, the RPAG then implies that there may be collusion between the medical profession and the hearing aid specialists, "attributed to the fears of some physicians that audiologists might usurp some of their territory" and that "many (physicians) are not knowledgeable about the special services which audiologists can render." It seems strange that a member of the medical profession should be cited as an authority on the one hand as a critic of hearing aid specialists, while in the next breath, the medical profession is chastised for self-interest and lack of knowledge of services in the hearing health care field. Logic does not support both statements, and surely, here again, the RPAG has made selective use of data to exaggerate the need for clinical audiology as a part of hearing health care. This is evident from the comparison between audiologists and hearing aid dealers, which must be regarded only as the opinion of the author. This is a transparent attempt to discredit hearing aid specialists, for the benefit of the audiologists. Our sense of justice compels us to reject the notion that a person who earns his living through the sale of a product is any less trustworthy or less honest than a person who is paid a fee for his services.

Other areas of the report demonstrate similar bias in an obvious attempt to prove that only clinical audiologists are qualified to serve the best interests of the hearing impaired. There is a marked inference that the other members of the hearing health team—the otologists, otolaryngologists, and hearing aid specialists—who have a long and distinguished record of service in the field, should no longer be entrusted with this responsibility. The strong influence of clinical audiologists in preparing this report is apparent from its contents, while the report speaks to the self-interest and conflicts of interest by other members of the hearing health team, it would appear that the report itself reflects the self-serving nature of clinical audiology. It is noteworthy that a clinical audiologist, Dr. Angela Loavenbruck, was a member of the RPAG which wrote this report, and testified at the Senate hearings, but, although this was labelled as a "Hearing Disability Study", no other discipline on the hearing health team was represented on the study group. (See p. 55, Real Issues Obscured—with supporting documentation as indicated—NHAS statement.)

SOME SPECIFIC INACCURACIES

The contents of other sections of this summary have been discussed in other materials supplied by the National Hearing Aid Society and the Hearing Aid Industry Conference. These include: a reply to the Baltimore "study," a reply to the MPIRG report, a complete description of the NHAS Certification program, which was inaccurately reported by RPAG, an evaluation of the RPAG Model Licensing Bill, an outline of the consumer protection and medical referral features of the NHAS/HAIC Model Bill, the actual consumer satisfaction levels as measured by objective studies and data supplied regarding price and profits. For the sake of brevity, we will not repeat those in this report. However, some other parts of the summary are incorrect and deserve additional comment. The discussion of the history of the hearing aid dealer licensing program and the participation of NHAS and FTC are inaccurate. To correct the record on all points may be irrelevant and would require too much space. Perhaps the FTC would prefer to reply on their own behalf to the charges.

At another point, the RPAG criticized the industry for preparing to defend itself against their attack, and raises objections to a press release prepared by the industry prior to the release of the complete RPAG report. Yet, at the time the industry distributed this release to its State Chapter Officers, for use only if necessary and appropriate, Nader groups had already captured headlines in Minnesota and Baltimore with "studies" which were biased, inaccurate, and sur-

*See p. 157.

reptitious. The results created irreversible damage to the confidence of the hearing impaired, and to the good reputations of many, many ethical and competent hearing aid specialists. The industry also knew that from the time that there was a change in leadership on the study, which occurred early in 1973, the National Hearing Aid Society was no longer consulted by RPAG, who ignored and disregarded the value of the information which we could provide to assist them with the study.

From these experiences, the hearing aid industry was able to correctly anticipate and predict the bias and inaccuracy which would follow in the final report. The industry was well aware of the influence of some clinical audiologists on the report, and their avowed purpose is now well-known i.e.—to eliminate the hearing aid specialists. By mobilizing on a nationwide scale, for immediate response to the unfair criticisms which could easily be anticipated, the industry hoped to mitigate the damage to the hearing impaired created by the resulting confusion and preserve the good reputations of the thousands of competent and reputable hearing aid specialists.

ALTERNATIVE DELIVERY SYSTEMS

The RPAG report alludes to Master Plan as a possible model for a lower cost delivery system. This assertion deserves careful examination, for in any estimate of costs, it is important to determine what services or goods are included in the cost. A raw cost figure can be deceiving. It is our understanding that Master Plan delivers only the hardware, without providing all of the many related and necessary services which are so important to the well-being of hearing aid users. The industry has taken the position that high quality services are an essential part of the hearing aid delivery system. Studies have shown that this service is an essential ingredient in consumer satisfaction, and imply that consumer satisfaction might be greatly diminished if these services were eliminated. (See page 66—Cost Factors—NHAS Statement.).

The testimony of the National Hearing Aid Society to the U.S. Senate Subcommittee on Consumer Interests of the Elderly described the present price structure, the service system, and presented objective data from qualified authorities showing that the hearing aid specialist's profits and income are reasonable. This information refutes the RPAG summary, "High Prices are Built Into the System."

However, comment is desirable on the section, "Hearing Aids and Service Distribution by Trained Audiologists." In this section, it is recommended that a nonprofit corporation be established in every major city to be managed by a board of directors. They would buy hearing aids at wholesale prices which they would supply to hearing and speech clinics, practicing audiologists and other hearing health groups. They would also establish a repair depot "similar to the system used by the Veterans Administration."

Here, again, as the title of the section indicates, the clinical audiologists are aggrandizing themselves, and advocating a system which would insure an expanded role for their own profession. This is impractical, and poses a very real problem for the hearing impaired, who would be severely inconvenienced by the necessity of reaching metropolitan centers for care for their hearing loss and may even be discouraged from obtaining necessary care. Furthermore, the data which is available at this time indicates that this system would be far more costly in the long run.

The RPAG has not indicated what they define as a "major city". However, if we arbitrarily establish a population of 250,000 as "major", we find that there are only 56 cities in the whole United States with a population of 250,000 or more. (Municipal Yearbook, 1973).

The RPAG has not indicated how the services of the clinical audiologists in the programs would be financed. If they are paid by the taxpayers, as is currently the custom, the tax burden may be quite high, judging from data which is available. (See testimony of Donald Krebs, Ph. D., at Senate hearings.*) On the other hand, if the fees for the clinical audiologists are paid by the consumers themselves, this would ultimately result in higher total costs to them. They would need to pay not only separate fees for the audiological services, in addition to the cost of the hearing aid, but would also need to pay for transportation costs to reach the metropolitan centers, as well as meals, lodging, or pay lost due to absence from work.

*See Hearing Aids and the Older American, part 2, p. 204.

Any discussion of true costs must also include the costs of facilities, equipment, supportive personnel, overhead such as heat and lights, and numerous other hidden costs which must be calculated in the total. This consideration raises questions about the VA cost figure of $200 per hearing aid, which was quoted by RPAG. While they mention some items which are included in the cost, they do not include the cost of facilities, equipment, heat, lights, stationery, supportive personnel such as receptionists, clerks, and secretaries, record keeping, printing of forms, and the thousands of other hidden costs which are part of the necessary expenses of hearing aid specialists, who receive no tax subsidy. Quite the contrary, with the taxes they pay, they contribute heavily to the support of government. The estimates of the price of VA hearing aids is highly in error if they are not based on proper cost accounting methods, which attribute a fair share of overhead costs to each hearing aid. Apparently, they do not.

In addition, the VA system of repairs results in delays and inconvenience that veterans are generally provided with two hearing aids, so that they will have a spare to use while repairs are being made. This, of course, results in increased costs per person served.

LETTER TO ALEXANDER M. SCHMIDT

In the letter to Alexander M. Schmidt, Miss Griesel makes some sweeping generalizations without necessary supporting data to verify them. Many of these generalizations deserve question, but one of the more vicious statements says, "Another problem identified by experts in the field is that audiometers are not properly calibrated, *particularly in hearing aid dealer establishments.*" (Emphasis added.) First, who are the "experts" and why are they not identified so that we may evaluate their qualifications for such a statement? Who checked the calibration of these audiometers, and how many hearing aid dealer establishments were checked? Miss Griesel presents no data whatsoever to support this claim, and it must therefore be regarded as only her own opinion. The National Hearing Aid Society has no quarrel with the concept of establishing high standards, and in fact, has been one of the primary constructive forces in that direction. However, it would seem capricious and arbitrary to impose discriminatory standards on hearing aid specialists without applying them uniformly to all members of the hearing health team.

LETTER TO CASPAR WEINBERGER

Miss Griesel advocates in this letter that a hearing aid delivery system similar to VA be established for Vocational Rehabilitation, Medicaid, the Office of Education and the Children's Bureau. Members of the National Hearing Aid Society are already serving the needs of these programs, and their accomplishments have won praise from key administrators of the programs. The VA system fails in many important respects, such as inconvenience to the recipients, travel time to reach the centers, and high costs to taxpayers.

The National Hearing Aid Society has proposed a system for providing hearing aids under Medicare which has been tested and proven. The details of the plan have been presented for consideration by the United States Senate. This plan recommends a medical examination prior to fitting a hearing aid, and places the hearing loss under the management of the medical ear specialists. When the care of an audiologist would be beneficial in the judgment of the medical specialist, it will be recommended. But, to require audiological care in every instance is unnecessary, and only adds to the delay, expense, and inconvenience. NHAS believes that the medical specialist is best qualified to manage the hearing loss.

RPAG MODEL LICENSURE LAW FOR HEARING AID DEALERS

The National Hearing Aid Society has submitted an analysis of the RPAG Model Bill, which shows in detail that the bill, proposed as a consumer protection measure, would actually result in harm to consumers due to vague, ambiguous, and inconsistent sections, which would make the law difficult to interpret and to enforce. The summary of the bill, which is presented by RPAG, however, contains time-honored abstractions, similar to motherhood and patriotism. Consumer protection is a worthy objective, and it is the objective of the National Hearing Aid Society. However, any consumer protection measures proposed must be carefully analyzed to insure that the goals are achievable with them, and would not in reality, create chaos and confusion.

The RPAG Model Bill is not realistic. The licensing laws which have been enacted for hearing aid specalists in 38 States are, and their enforcement will truly achieve consumer protection.

ITEM 17. RESOLUTION 13, A POSITION PAPER OF THE AMERICAN SPEECH AND HEARING ASSOCIATION*

COMPREHENSIVE AUDIOLOGIC SERVICES FOR THE ELDERLY

Whereas, a number of plans are being considered both nationally and in the various states which relate to the dispensing of hearing aids to the hearing impaired, and

Whereas, such plans have a direct bearing on the quality of care provided in the future to the hearing impaired, and thus a direct bearing on the profession of audiology, and

Whereas, a need exists for the ASHA to enunciate its position in this matter, and

Whereas, a position paper submitted by the Committee on Rehabilitative Audiology has received careful consideration,

Be it resolved, That the American Speech and Hearing Association supports the concepts and principles embodied in the following position paper.

I

The profession of audiology is confronted with the distressing realization that the rehabilitation of the hearing impaired is not always being accomplished in the best interests of all children and adults who have auditory deficits. The profession needs a clear definition, acceptance and implementation of the audiologist's role in the management of the communicative problems of the hearing impaired.

Audiology is a profession concerned with the *nonmedical management of the hearing impaired from detection of the problem to the resolution of communicative needs.* Audiologic rehabilitation is viewed as a dynamic and critical process which involves assessment of human communicative status, formulation of remedial plans relative to the solution of problems, implementation of remediation, and evaluation of remediation and reassessment.

Audiology is responsible for the habilitation and rehabilitation of the speech perceptual-communicative efficiency of the individual with auditory disability. Therefore, audiologic assessment must *not* be restricted to differential evaluation of auditory function for the sole purpose of medical diagnosis. The audiologic evaluation should include:

a. Assessment of Listening Function. This may include descriptions of speech perception in competing noise and competing messages, descriptions of speech perception for connected speech, determination of the temporal capacities for speech comprehension, definition of the effective distance for auditory reception, and definition of the auditory memory for speech.

b. Descriptions of Linguistic Ability.

c. Assessment of Auditory Sensitivity.

d. Gathering Functional Evidence Related to the Anatomic Site of Pathology.

e. Evaluation of Speech-Perceptual Effects of the Interaction Between the Hearing Aid and the Hearing-Impaired Listener.

f. Assessment of the Efficiency of Modified Communication Behavior.

The development of a total plan of remediation is a crucial stage in the process of habilitation. It involves the interpretation of the findings of the assessment phase, and the development of a program designed to meet the evident needs. This involves improving the communication system through amplification and training, determining the most effective approach to structured counseling, and finding means of reducing or resolving associated educational, social and vocational problems.

In actual practice, today, audiologic services often involve only the assessment and differential evaluation of auditory problems, on a general recommendation regarding the use of hearing aid amplification. Thus, even before a rehabilitation plan has been fully formulated, the management of the hearing impaired may be discontinued or left in the hands of a hearing aid dealer, a

*See statement, p. 27.

child's teacher, a physician, or members of the family. None of these individuals, operating independently, can or do provide all of the services which are often needed for the proper management of the hearing impaired. Rather than limiting himself to the assessment of auditory function, the audiologist must be responsible for initiating the habilitative-rehabilitative process. This includes careful evaluation of communicative performance with and without amplification, eventual specific decisions regarding a hearing aid, training in the use of amplification, optimal perception of acoustic information and supplementary cues from other sensory modalities, counseling of the individual and his family, and continual supervision of communication skills, including hearing aid performance. Rehabilitation also demands that the audiologist marshal community resources for the reduction or elimination of associated personal, educational, or vocational problems. In addition, any efficient service system will incorporate methods for evaluation of procedures and decisions. Under the present system of delivery of audiologic services, there is little or no opportunity for the evaluative phase to take place since the client often does not remain under the audiologist's care following the recommendation of a hearing aid.

Rehabilitative audiology is needed and will come into its own when the goal for hearing-impaired people is recognized not just as auditory assessment or referral to a hearing-aid dealer, but as the attainment or maintenance of communicative ability.

Such a goal demands a comprehensive plan of action, implementation of the remedial plan, and establishment of criteria for evaluating the effectiveness of the program.

An acceptable program of rehabilitation, following medical consultation, must include appropriate audiologic, consultative and technical resources, continuing research directed toward the rehabilitative process, and a system for the delivery of services to the public which is efficient, professionally objective, economically sound, and in the best interests of those who are served. It is the position of the American Speech and Hearing Association that audiology service units which meet the standards of the Professional Services Board, American Boards of Examiners in Speech Pathology and Audiology, should be in a position to provide comprehensive services for the resolution of communicative problems experienced by the hearing impaired.

II

The provision of more efficient speech reception in the hearing-impaired individual is a fundamental responsibility of the audiology profession. Hearing aid amplification is an important tool available to the audiologist in his efforts to habilitate and rehabilitate such individuals. Indeed, other aspects of the habilitative-rehabilitative process are defined and limited by the capability of the recommended hearing aid to provide the optimal acoustic signals which are needed in each individual case. Only after all possible restoration of auditory function is achieved through the effective use of a hearing aid does the audiologist usually consider the role of other sensory channels, such as those of vision and touch.

Speech is an auditory phenomenon. For this reason there can be no compromise with excellence in the selection of a hearing aid. The goal must be optimum auditory functioning. To be satisfied with less is to force the hearing-impaired person to rely on sensory channels not designed for the reception of speech. Other aspects of the habilitative-rehabilitative process, such as counseling, speech reading, auditory training, and speech and language training are vitiated to the extent that professional responsibilities concerning hearing aids are relinquished. However, the selection and effective utilization of classroom amplifying systems requires audiologic knowledge and supervision.

Because of the importance of optimal hearing-aid amplification to the habilitative-rehabilitative process, audiologists must be in a position to assume the major responsibility in the selection of hearing aids for their clients. The practice of making general recommendations regarding amplification, and then leaving the selection of the aid to a hearing aid dealer who is not affiliated personally with the audiology service center, can represent an abrogation of professional responsibility on the part of the audiologist. This is especially true in cases of children and adults who are in need of a comprehensive program of habilitation-

rehabilitation of which hearing aid amplification may be only one of a number of pertinent needs. The selection of an appropriate aid requires extensive knowledge of the performance characteristics of hearing aids combined with information about the particular auditory parameters necessary to utilize maximally each client's residual hearing. In addition, professional skills must be utilized in affecting positive changes in human behavior. Clearly such knowledge and skills lie within the expertise of the professional audiologist.

Hearing aid selection procedures have evolved over some thirty years because the profession of audiology initiated procedures for hearing aid selection. The development of techniques, methods, and materials in assessing and comparing wearable hearing aids has come largely from audiology. Much progress has been made in hearing aid design engineers. But much more progress is needed. The goal of accurately defining and delineating all hearing aid performance variables has not yet been fully reached. It is not known with certainty the type of speech signal and the conditions of hearing evaluation which can best detect significant electrostatic differences among hearing aids.

Without primary and continued responsibility for evaluating and selecting hearing aids, the motivation and opportunity for research would diminish significantly. Such an eventuality would have serious negative implications in the future professional care of the hearing impaired.

III

At the present time, the Code of Ethics of the American Speech and Hearing Association explicity prohibits any member from engaging "in commercial activities that conflict with his responsibilities to the persons he serves professionally or to his colleagues." In essence, this professional guideline has prevented the audiologist from being involved in the direct sale of hearing aids or accessories for many years. It is obvious that this principle has been based on the assumption that the sale of such instruments and equipment would constitute a conflict of interest on the part of the audiologist. As a result, the present system of hearing aid dispensing utilized throughout the country generally prohibits the audiologist from completely fulfilling the professional responsibilities to the hearing impaired which have been discussed above. Since sales can only be made by hearing aid dealers who are usually operating as independent businessmen with no formal training in the rehabilitative process or affiliation with those centers which provide audiologic services, and because audiologic consultation and management is often neglected in the present system, exploitation of the hearing impaired can occur. The implementation of comprehensive service programs for the hearing impaired is often impossible. As a result, the best interests of every patient in need of such services are presently not being met. The current system is often inefficient, costly, and confusing to the patient. It is generally without professional management.

By professional control of the entire habilitative-rehabilitative process, including the dispensing of hearing aid amplification, problems such as the following can be resolved:

1. Inadequate communicative adjustment
2. Unrealistic auditory expectations
3. Unrealistic familial expectations
4. Inappropriate electroacoustic performance
5. Deficient listening behavior
6. Negative attitudes toward, and rejection of, amplification
7. Excessive cost.

The dispensing and follow-up case of hearing aids should be a part of the total professional services which may be conducted in audiology centers which are accredited by the American Boards of Examiners in Speech Pathology and Audiology. In order to avoid conflict of interest and adherence to the principles of professional ethics, administrative and fiscal arrangements for the provision of complete hearing aid services must be designed in such a way that professional objectivity is maintained by staff audiologists. The American Speech and Hearing Association is in support of those plans for the delivery of health services whether of a governmental or independent nature, which will support the implementation of these principles.

Appendix 3

LETTER FROM ANTHONY DI ROCCO, EXECUTIVE SECRETARY, NATIONAL HEARING AID SOCIETY, TO WILLIAM ORIOL, STAFF DIRECTOR, COMMITTEE ON AGING, SUBMITTING NHAS PLAN FOR HEARING AID PROCUREMENT UNDER MEDICARE, DATED FEBRUARY 12, 1974

FEBRUARY 12, 1974.

DEAR MR. ORIOL: In response to your request, we are pleased to submit in greater detail the National Hearing Aid Society's plan for procurement of hearing aids under Medicare.

We believe that our NHAS plan is practical, consistent both with current practices in the hearing aid field and the present Medicare program, and could be implemented at reasonable cost. We have attempted to define standards and provides sufficient monitoring to insure that the elderly receive proper care. Some of the highlights of the NHAS plan are:

Rather than create new and expensive bureaucratic structures, the NHAS plan proposes to use the full strengths of the existing hearing health team—the otologists, or otolaryngologists, the hearing aid specialists, and the clinical audiologists. Since the private practitioners in the hearing health field presently maintain offices equipped to carry out the program, this plan avoids the necessity for capital expenditures from public funds to provide equipment and facilities.

The medical specialists (otologists, otolaryngologists, or physicians in general practice) are given the responsibility for the management of the hearing loss, consistent with current practices in the hearing health field.

The NHAS plan gives the client maximum freedom of choice among Medicare providers consonant with the objective that the client receives the best possible help for the particular hearing problem.

The NHAS plan assures Medicare of the most economical way of fitting and providing hearing aids to qualified persons, insuring optimum benefits for the greatest number of people.

The NHAS plan coincides with present practices under Medicare, minimizing administrative problems in implementing the program.

This represents a basic plan and if modifications appear desirable at a later date, we will be sure to advise you.

Should this plan be accepted by the U.S. Senate Committee on Aging and Congress, we recommend that rules and regulations be written which would reinforce the standards we have suggested here. The services of the National Hearing Aid Society would be available to assist the Social Security Administration in the development of rules which would offer maximum benefits to the elderly hearing aid recipients.

We compliment your Committee for giving such serious consideration to this question. We have believed for many years that millions of elderly hearing impaired could lead richer, fuller lives if they could obtain proper care for their hearing loss. For many of them, a hearing aid may mean the difference between full participation in the mainstream of society, and isolation.

Sincerely,

ANTHONY DIROCCO,
Executive Secretary.

Enclosure.

NHAS PLAN FOR HEARING AID PROCUREMENT UNDER MEDICARE

INTRODUCTION

The National Hearing Aid Society supports and encourages the enactment of legislation designed to provide assistance from public funds for hearing aid procurement and related services for the elderly who qualify for Medicare, so that the benefits of hearing aids can become more readily available to the elderly hearing impaired.

In the following plan, the National Hearing Aid Society suggests guidelines for implementing such a program and proposes an administrative structure consistent with current Medicare practices. This plan incorporates controls to provide optimum care and maximum efficiency and suggest a plan for reimbursement to providers.

BASIC FEATURES OF THE PLAN

Rather than create new and expensive bureaucratic structures, the NHAS plan proposes to use the full strengths of the existing hearing health team—the otologists or otolaryngologists, the hearing aid specialists, and the clinical audiologists. Since the private practitioners in the hearing health field currently maintain offices equipped to carry out the program, this plan would avoid the necessity of capital expenditures from public funds to provide equipment and facilities.

The medical specialists (otologists, otolaryngologists, or physicians in general practice) will be given the responsibility for the management of the hearing loss, consistent with current practices in the hearing health field.

The NHAS plan will give the client maximum freedom of choice among Medicare providers consonant with the objective that the client will receive the best possible help for the particular hearing problem.

Finally, the NHAS plan assures Medicare of the most economical way of fitting and providing hearing aids to qualified persons.

DEFINITIONS

The *otologist* is a licensed physician specializing in diagnosis and treatment of diseases of the ear. The *otolaryngologist* is a licensed physician specializing in the diagnosis and treatment of diseases of the ear, nose and throat.

The *hearing aid specialist* is a person who engages in the testing of hearing, selection, adaptation, selling and servicing of hearing aids, and the instruction and counseling pertaining thereto. The hearing aid specialists also take the impression for fabricating an earmold. In those states with licensing for hearing aid specialists (38 at this writing), all personnel testing for hearing aid recommendations, and selecting, and adapting hearing instruments shall be licensed under the state's hearing aid specialists licensing act. In those states which are not licensed, the hearing aid specialist must have a minimum of two years experience in the testing of hearing, and the selection and adaptation of hearing instruments, and shall have conducted their businesses according to the Code of Ethics of the National Hearing Aid Society, the Hearing Aid Industry Conference, and the Trade Practice Rules for the Hearing Aid Industry of the Federal Trade Commission.

The *clinical audiologist* is a non-medical specialist in rehabilitation of persons with hearing loss. In those states with licensing for clinical audiologists (11 at this writing), the clinical audiologist providing services must be licensed under that state's laws regulating the practice of Audiology. To qualify to render services under Medicare in those states without licensing, the clinical audiologist must hold a degree in Audiology from an acredited institution of higher education.

CRITERIA USED IN DEVELOPING NHAS MEDICARE PLAN

The NHAS plan for hearing aid procurement under the Medicare program conforms with the following criteria:

1. Maximum competence must be assured in the testing of hearing, fitting and adaptation of the hearing aid, and post-fitting instruction and counseling to promote maximum satisfactory adjustment to hearing aid use.

2. Public funds are utilized in a manner which achieves maximum benefits at lowest possible cost; the interests of the taxpayers are appropriately considered by making maximum use of the established and successful delivery system now available through the private sector. This plan avoids the establishment of overlapping and costly government machinery for administering the program.

All of the cost factors of any other plan for dispensing hearing aids under Medicare should be compared to the NHAS plan, which includes not just the cost of the instrument itself, but also the costs of facilities and equipment, salaries of personnel, overhead costs common to the operation of all offices such as maintenance, telephone and lights, as well as dozens of other hidden costs.

3. The NHAS plan appropriately recognizes the special problems of the aging, such as chronic infirmities which limit mobility, transportation problems, and

financial problems, and creates a system which offers maximum convenience and a minimum strain to the recipients in obtaining care.

The geographical distribution of hearing aid specialists in the United States coincides and is proportionate to the general population distribution, and therefore offers the convenience of local facilities and skilled services throughout the country.

ADMINISTRATION OF THE MEDICARE HEARING AID PROGRAM

The Medicare hearing aid procurement program shall be administered by the Social Security Administration Regional Advisory Councils consisting of three hearing aid specialists, one otologist or otolaryngologist, and one clinical audiologist shall be established to advise, assist, review, and make recommendations to the Social Security Administration regarding implementation of the program. The Advisory Council shall be responsible to the Social Security Administration.

PROCEDURES

Hearing aids will be furnished to Medicare recipients under the following procedures:

Potential candidates for hearing aids shall be examined by an otologist or an otolaryngologist certified by the American Board of Otolaryngology or eligible for certification. In those cases where the services of those specialists are not available because of distance, or where this requirement would impose extreme hardship on the recipient, the recommendation of a physician in general practice shall be acceptable. The otolaryngologist (otologist, or physician shall make tests for diagnostic purposes. (Enclosed is a sample of the medical procedures adopted by one state, indicating the tests by the physician which are required in that state for Medicaid.) If the patient shows any pathology that may benefit from treatment or surgery, the physician will initiate appropriate therapy to obtain recovery.

When examination reveals no pathology, or after the completion of necessary therapy, and sufficient hearing loss remains, the patient will be considered a candidate for a hearing aid, and the physician will complete the following statement on the Medicare Hearing Aid Procurement Form: "After consideration of the history and physical condition of the above named patient, I recommend that he/she be fitted with a hearing aid," and will advise the patient to consult a hearing aid specialist.

If the physician in his diagnosis determines that the services of a clinical audiologist are necessary, he will advise the patient to consult a clinician, who will conduct hearing tests for diagnostic purposes as directed by the physician. A maximum of two clinical consultations by clinical audiologists will be allowable for reimbursement by Medicare. If the physician employs a clinical audiologist, such services will be accepted within the two allowable consultations.

THE HEARING AID SPECIALISTS' RESPONSIBILITY IN PROVIDING HEARING AIDS UNDER MEDICARE

The hearing aid specialist will evaluate carefully the recipient's ability to benefit from a particular type or style of hearing aid. It shall be the responsibility of the hearing aid specialist to select hearing aid instrumentation with regard to:

1. Motivation and attitude toward hearing aid use by the client
2. Ability to manipulate controls
3. Previous hearing aid experience
4. The degree and type of hearing loss
5. Consideration of the individual life style and environment in which the hearing aid will be used.

This evaluation shall continue during post-fitting care. A minimum of four appointments shall be arranged during the first six months after delivery to assure the recipient the opportunity to discuss any problems and receive necessary assistance. A standard audiometric-hearing test form shall be developed for use in all hearing aid fittings under the Medicare program. All tests and information requested on the form must be completed before any claim will be paid. (See attached sample of form used for Medicaid in Indiana.)

No binaural fitting of hearing aid instrumentation will be made without prior approval of the referring physician and a written report must be made by the

hearing aid specialist explaining the justification for the binaural fitting, and must include audiometric data.

As a general policy, no replacement hearing aid fittings for Medicare recipients will be made where the hearing aid in use is less than five years old, unless tests indicate that a substantial change has occurred in the candidate's hearing which renders the previous aid ineffective, or unless the hearing aid is proven to be damaged beyond repair, or a loss of the hearing aid has been certified and substantiated.

During the first three years the Medicare plan for hearing aid procurement is in operation, it will not provide batteries, cords, or repairs. This is purposeful, to prevent an avalanche of current hearing aid users who would be eligible for these services immediately.

REQUIRED TESTS, EQUIPMENT, AND ENVIRONMENT AND SERVICES

Testing Environment

The ambient noise levels of the testing environment shall not exceed 50 dB on the "A" scale to prevent a shift of threshold of the normal ear.

Tests

The hearing aid specialist shall conduct the following tests to provide guidelines in the fitting of the hearing instrument:

1. *Pure Tone—Both Ears—*

(*a*) Air—at least the following frequencies should be tested: 500 cps, 1000 cps, 2000 cps, 3000 cps. 4000 cps. (Intensity level in 5 dB steps from 0–90 minimum.)

(*b*) Bone.

(*c*) Air masking—Masking should be employed when there is a 30dB or greater difference in any of the above frequencies, between the threshold of the ears.

2. *Speech Testing.*—Speech reception thresholds (SRT and speech discrimination scores may be accomplished either by live voice or recorded speech presented through a speech audiometer meeting specified standards, as stated on the Medicare Hearing Aid Procurement Form).

A. Threshold tests—Right and left ear:

(*a*) S.R.T. (Speech Reception Threshold).

(*b*) M.C.L. (Most Comfortable Loudness Level).

(*c*) T.D. (Threshold of Discomfort).

B. Discrimination:

(*a*) Left.

(*b*) Right.

(*c*) Binaural (recommended but not mandatory).

C. Suitable tests performed to demonstrate sufficient improvements in hearing results by the use of the hearing aid(s).

3. Ear inspection—the hearing aid specialist shall make inspection of the ear canal with an otoscope or suitable light to determine the advisability of taking an ear impression for the use of an earmold.

Earmolds

In all final fittings of air conduction instruments, a custom earmold, acoustically fitted and made from an ear impression, must be provided with the hearing aid.

Hearing Aid Delivery Confirmation

Immediately after the delivery of the hearing aid, the hearing aid specialist shall forward copies of the audiogram, the SRT, the MCL, and the TD along with the name of the make and model of the hearing aid and the Medicare Hearing Aid Procurement Form to the Medicare fiscal agent for their records. Additionally, the hearing aid specialists shall keep records on each Medicare client for at least seven years.

Post-Fitting Service

Upon delivery of the hearing aid, the hearing aid specialist will carefully instruct the client in its care and use, and encourage him to avail himself of post-delivery care services. A minimum of four follow-up appointments will be arranged within the first six months. The responsibility for completing these appointments will rest with the recipient.

Equipment and Facilities

The hearing aid specialist shall have the following equipment and facilities available:

1. *Audiometer.*—The audiometer shall be checked or calibrated at any time there is an indication that it is not functioning properly, and once a year at least. Proof of calibration and/or repairs should be available. The audiometer should be checked daily by a simple listening test by the person doing the testing. This is important to ascertain that the test results are accurate.

The pure tone audiometer shall meet the ANSI or ISO 1964 standards, and the standard used shall be indicated on the Medicare Hearing Aid Procurement Form. An audiometer must be available with a speech circuit that meets ANSI specifications, the output of which shall provide earphone levels of 100 dB . . 002 dynes/cm.

2. *Inventory.*—The hearing aid specialist's office shall have available, or access to a selection of hearing aid models, hearing aid supplies, and services complete enough to accommodate the needs of hearing aid users:

A. Access to an adequate selection of models including an appropriate selection of instruments with various performance characteristics.

B. An adequate selection of accessories.

C. Maintain, or have access to, standardized test and repair facilities.

D. Maintain, or have access to, facilities for making earmolds.

3. *Established Office.*—The hearing aid specialist shall maintain an office which is open at reasonable and customary times for the public to have access to services. These hours shall be posted in a conspicuous location in the office.

CASES IN WHICH THE HEARING AID SPECIALIST IS THE INITIAL CONTACT FOR THE CLIENT

In those cases where candidates for a Medicare hearing aid initially consult a hearing aid specialist, the hearing aid specialist shall conduct screening tests to determine whether the hearing loss is sufficient to require further attention. If so, the hearing aid specialist shall refer the client to an otologist or otolaryngologist for examination and determination of the need for a hearing aid, or medical or surgical intervention as outlined in this plan. If a hearing aid is needed, the physician shall then refer the client back to the hearing aid specialist who made the referral.

REIMBURSEMENT

Those who receive Social Security payments at average or above will pay the first $50.00 for the hearing aid. Those who are receiving Social Security payments below the average will receive needed hearing aids at no cost to them.

Providers will be reimbursed according to the plan now used by Part B of Medicare, which provides that maximum allowable charges are based on the 72 percentile of charges by all providers in any given region.

[SAMPLE]

GUIDELINES FOR MEDICAL CLEARANCE

(As set up in the Indiana Medicaid Program)

A hearing aid should not be approved for a patient prior to that patient's having had a medical examination. Preferably, this examination should be accomplished by an otologist or an otolaryngologist, if available and accessible, but certainly a basic medical survey should be given by a general practitioner. All children under six years of age must be seen by an otologist or otolaryngologist before hearing aid is fitted.

The reasoning behind this requirement is quite clear. First of all, a hearing loss is a medical problem. In a great number of instances, the hearing loss can be corrected medically without the need for a hearing aid. Furthermore, and perhaps as importantly, the hearing loss may well indicate that a disease process is present, either locally within the ears or at a distance—which is in proximate need of medical attention for the general health and welfare of the patient. In some instances, a hearing loss may indicate a condition which, untreated, is otherwise fatal. Moreover, there are other situations in which hearing losses are found—where the use of the hearing aid is contraindicated by the medical situation which is present.

Recognizing the unavailability of qualified medical care in all instances, the following minimal medical assessment should be required before the fitting of any hearing aid.

History

1. Is there any evidence of infection or drainage from either ear.
   Remarks.—
2. Is there any significant headache, vertigo, or dizziness, nausea, or vomiting.
   Remarks.—
3. Please make a statement, indicating whether the hearing loss has been gradual or sudden in onset.
   Remarks.—

Minimal physical examination should be sufficient to rule out:

1. Presence of pus in the ear canal
2. Perforation of the eardrum
3. Impacted cerument
4. Presence of external ear canal infection
5. The possibility of the complete closure of the ear canal

An additional statement should be included under medical evaluation to the effect that the patient can hear and understand amplified sound, either through a speaking tube or a loud voice at the ear.

Additional physical examination which is desirable but not obligatory:

1. Presence of recorded tuning fork examination—indicating the results of Rinne, Schwaback and Weber tests.
2. A brief note is desirable on the neuro-otological examination, including the presence or absence of nystagmus, reaction of pupils to light and in accommodation, and presence of corneal reflexes.

In addition to the above, which should be performed by a licensed physician, if the audiometric findings which are forwarded with the patient's examination indicate a discrimination score less than 50 per cent, the patient should be referred to a specialist.

At the conclusion of the portion devoted to medical examination, two statements will appear with instructions for the physician to check the one applicable. "After consideration of a history and physical findings of the above mentioned patient, I recommend: (check appropriate box).

☐ The patient be fitted for a hearing aid.
☐ The patient be referred for further medical evaluation."

----------, M.D.
Signed

AUDIOMETRIC TESTS AND BACKGROUND INFORMATION
(Sample Form taken from the Indiana Medicaid Program)

STATEMENT OF EXAMINING PHYSICIAN:

"After consideration of a history and physical findings of the above mentioned patient, I recommend: (check appropriate box).

☐ The patient be fitted for a hearing aid."
☐ The patient be referred for further medical evaluation." _____ M.D.
signed

INFORMATION TO BE PUT ON THE AUDIOMETRIC FORM FOR MEDICAID CASES

Equipment to be used for hearing tests provided for on this form, must meet the following standards: I. Puretone audiometer for air and bone conduction testing which must meet ANSI standards calibrated ISO 1964 II. Audiometer with a speech circuit which meets ANSI specifications, the output of which must provide earphone levels of 100 dB re: .0002 dyne/cm^2.

Note: Live-voice testing through a calibrated speech circuit with a speech audiometer meeting above standards – may be used until May 1, 1972. After May 1, 1972, SRT and speech discrimination scores must be accomplished by recorded speech presented through a speech audiometer meeting standards given above.

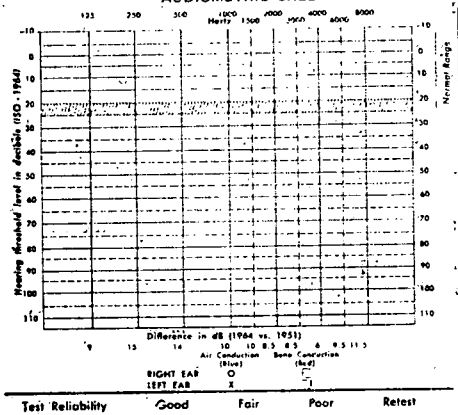
Children under six years of age must have a medical examination by an otologist or an otolaryngologist before being fitted with a hearing aid under the Medicaid Program.

If audiometric test findings for speech discrimination, using audiometric equipment meeting the standards designated above, and procedures prescribed on this form, indicate a speech discrimination score (in either ear) of less than 50 per cent, the patient must be referred for otological or otolaryngological examination before a hearing aid is fitted.

If, in puretone testing, a bone-air gap of more than 15dB occurs, this must be reported to the referring physician who signed the medical clearance, for a decision regarding further medical examination by an otolaryngologist or an otologist.

NAME _____ AGE _____ MEDICAID # _____

AUDIOMETRIC SHEET



Test Reliability Good Fair Poor Retest

SPEECH TESTS

Speech Audiometry

Type of speech signal ☐ Recorded ☐ Live Voice

Speech reception threshold Right _____ dB Left _____ dB

Most comfortable level Right _____ dB Left _____ dB

Discomfort level Right _____ dB Left _____ dB

Speech discrimination scores:

Right _____% at _____ Hearing Threshold Level (HTL)

Right _____% at _____ Hearing Threshold Level (HTL)

Left _____% at _____ Hearing Threshold Level (HTL)

Left _____% at _____ Hearing Threshold Level (HTL)

*Rt. dB HTL Rigl

If masking used, describe procedure –

Remarks

"I have read the regulations and standards adopted and approved by the Indiana Department of Public Welfare, Indiana Blue Shield, Indiana Hearing Aid Association, and the Medical Clearance section approved by the Indiana Academy of Ophthalmology and Otolaryngology, for the fitting and dispensing of hearing aids for Medicaid cases, and I have followed the procedures provided therein. This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws."

SIGNATURE OF PROVIDER _____ REGISTRATION NO. _____

This form developed by the Indiana Hearing Aid Association
IS 2081-1071

SPONDAIC WORDS

(AUDITORY TEST – 14)
USED FOR THRESHOLD TESTING

This Spondee word list is recommended to establish Speech Reception Threshold (SRT). Use at least 25 Spondaic words for each ear tested. (If another word list is used, it must be attached to this test form).

LIST 1

1. grayhound
2. schoolboy
3. inkwell
4. whitewash
5. pancake
6. mousetrap
7. eardrum
8. headlight
9. birthday
10. duckpond
11. sidewalk
12. hotdog
13. padlock
14. mushroom
15. hardware
16. workshop
17. horseshoe
18. armchair
19. baseball
20. stairway
21. cowboy
22. iceberg
23. northwest
24. railroad
25. playground
26. woodwork
27. oatmeal
28. toothbrush
29. farewell
30. grandson
31. drawbridge
32. doormat
33. hothouse
34. daybreak
35. sunset

LIST 2

1. playground
2. grandson
3. daybreak
4. doormat
5. woodwork
6. armchair
7. stairway
8. cowboy
9. oatmeal
10. railroad
11. baseball
12. padlock
13. hardware
14. whitewash
15. hotdog
16. sunset
17. headlight
18. drawbridge
19. toothbrush
20. mushroom
21. farewell
22. horseshoe
23. pancake
24. inkwell
25. mousetrap
26. sidewalk
27. eardrum
28. grayhound
29. birthday
30. hothouse
31. iceberg
32. schoolboy
33. duckpond
34. workshop
35. northwest

SPEECH RECEPTION THRESHOLD Left Ear_____db
Right Ear_____db

PHONETICALLY BALANCED WORD TEST
USED TO TEST SPEECH UNDERSTANDING ABILITY

The Phonetically Balanced word list below is recommended to establish speech discrimination scores. Use at least 25 words for each ear tested. (If another Phonetically Balanced word list is used – it must be attached to this test form).

LIST 1

1. an
2. yard
3. carve
4. us
5. day
6. toe
7. felt
8. stove
9. hunt
10. ran
11. knees
12. knot
13. mew
14. low
15. owl
16. it
17. she
18. high
19. there
20. earn
21. twin
22. could
23. what
24. bathe
25. ace
26. you
27. as
28. wet
29. chew
30. see
31. deaf
32. them
33. give
34. true
35. isle
36. or
37. law
38. me
39. none
40. jam
41. poor
42. him
43. skin
44. east
45. thing
46. dad
47. up
48. bells
49. wire
50. ache

LIST 2

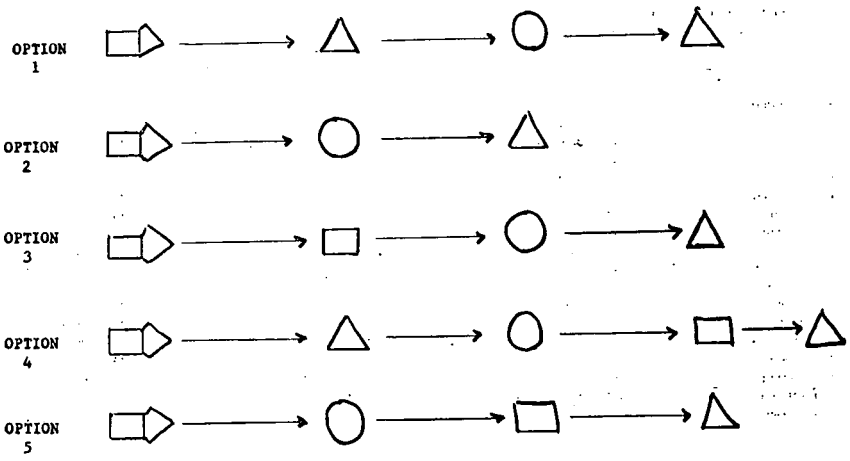
1. your
2. been
3. way
4. chest
5. then
6. ease
7. smart
8. gave
9. pew
10. ice
11. odd
12. knee
13. move
14. now
15. jaw
16. one
17. hit
18. send
19. else
20. tear
21. does
22. too
23. cap
24. with
25. air
26. and
27. young
28. cars
29. tree
30. dumb
31. that
32. die
33. show
34. hurt
35. own
36. key
37. oak
38. new
39. live
40. off
41. ill
42. rooms
43. ham
44. star
45. eat
46. thin
47. flat
48. well
49. buy
50. ail

PERCEPTION SCORE

LEFT_____% RIGHT_____%

NHAS MEDICARE HEARING AID PROCUREMENT FLOW CHART

(This illustrates the various options open to the hearing impaired in obtaining hearing aids under the NHAS Medicare Plan)



LEGEND

= RECIPIENT

= MEDICAL

= HEARING AID SPECIALIST

= CLINICAL AUDIOLOGIST