Contemporary Themes

Elusive allowances

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The disabled are confused about the development, prescription, and use of all health and welfare services available to them.¹ Among these services are cash benefits, and, whether they like it or not, the medical profession plays a large part in helping patients obtain them—for instance, by assessing eligibility. As part of a study on the level of knowledge and use of the health and welfare services by disabled people we inquired into the cash benefits that a sample of them received.

Methods and results

The sample was taken from registers held at a vehicles for the disabled centre in Edinburgh and an artificial limb and appliance centre in Glasgow. A total of 714 was selected at random from those living in South Scotland, of whom 255 became available for interview at home. Two-thirds of these were wheelchair users, most having had their chair for over a year. Most were elderly; over half had degenerative neurological or joint disorders, and one in 10 had had a leg amputated.

Some 63% of the sample received at least one form of cash benefit—excluding supplementary benefit, retirement pension, and war disablement pension (table I). Most had first learnt about the various allowances from the mass media—primarily the radio, followed by newspapers and television—and from chance meetings with informed

TABLE I—Results in percentages of how 255 subjects learnt about social security benefits

	Any special cash benefit	Attendance allowance	Mobility allowance	Invalidity benefit and pension	"Others"
Knew about allowance	85	58	58	25	13
Learnt about allowance from:					
General practitioner	12	15	12	16	6
Hospital staff	14	15	18	16	6
Community nurse	7	15	5	0	9
Area social worker	4	4	3	6	3
Relative	5	13	7	2	6
Miscellaneous (mass media, neighbours, etc)	56	39	56	60	70
Receiving allowance	63	38	24	20	9

people, such as neighbours. About a third, however, had gleaned their information from NHS sources.

One source of education and information is the mobile aids centre, which tours the country, as does a similar van in England and Wales. This provides, in a large vehicle, information and advice relating to aids, equipment, and services. Half of those interviewed were asked to visit the centre for instruction. Asked at the end of their visit what they had learnt about, 13% said "allowances." Follow-up showed that there was a considerable difference between those who had been to the centre and those who had not, in that fewer were still seeking help or advice about allowances.

Conclusion

People with a locomotor disability may be known to one specialised service only, but that does not mean they have difficulties only in that specific way. It is surely the responsibility

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TABLE II—DHSS cash benefits: a sample related to disability

Name	Type	Qualification	How to claim
Attendance allowance	Non-contributory	Over 2 years old; severely disabled and has needed looking after for at least six months. Two types available: day and night, or night only	Complete form in DHSS leaflet NI 205
Invalid care allowance	Non-contributory	Working age; men/single women unable to work because of caring for severely disabled relative in receipt of attendance allowance	Complete form in DHSS leaflet NI 212
Invalidity benefit	National Insurance	(a) Pension: Those claiming sickness benefit for over six months (b) Additional: Those chronically ill before age 60 (men) or 55 (women)	Submit medical certificates to social security office
Invalidity pension	Non-contributory	Working age; unable to work for six months; not sufficient NI contributions to get invalidity benefit. Married women eligible only if unable to do normal household duties	Complete form in DHSS leaflet NI 210 Married women—NI 214
Mobility allowance	Non-contributory	Between 5 and 65 years; unable or almost unable to walk because of physical disablement	Complete form in DHSS leaflet NI 211
Hospital patients travelling expenses	Means test unless on supplementary benefit/family income supplement/war pension	Outpatients and inpatients; recipients of supplementary benefit or family income supplement or low income group. Relatives of war pensioners—themselves if attendance related to their pensioned disablement	Supplementary benefit or family income supplement—take order book to hospital. Low income—form H11. War pensioner—ask at social security office
Rate relief	Non-contributory	Those who have had their home adapted because of their disability	Application form from local rates office

of everyone in health and social care to be aware of all the problems and their possible solutions. The medical profession should accept that knowledge of social security benefits is part of their responsibility. (The most important of these and how to claim them are given in table II.)

Department of Health pamphlets on social security benefits should be available in all general practice and hospital waiting rooms and on hospital wards, and copies should be given to all disabled patients or their relatives. Both groups should be told how to apply for benefits by a member of the health care team, whether doctor, ward sister, health visitor, or social worker. It is the doctor's responsibility to ensure that each patient

receives the medical services he requires. It should be accepted that this principle is extended to include referral for the appropriate social security allowance.

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Reference

¹ Blaxter M. *The meaning of disability*. London: Heinemann, 1976.

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For Debate . . .

Parkinson's disease and Alzheimer's disease as disorders of the isodendritic core

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Abstract

Parkinson's disease and Alzheimer's disease may represent two parts of a spectrum of disease characterised by a primary loss of cells of the isodendritic core. Secondary cell loss from the striatum and cerebral cortex therefore occurs as a consequence of the loss of ascending projections from the isodendritic cells. The anatomy of this system should provide a unique opportunity for therapeutic intervention. Neurotransmitter replacement treatment may be provided either by enhancing transmitter release by any remaining neurones or by direct agonists. The wide dispersal of the isodendritic projection systems affected in Parkinson's and Alzheimer's diseases and the possibility that they are tonically active create an opportunity for neurotransmitter replacement treatment.

Animal studies should be able to show whether such treatment can delay secondary cell loss, and, together with human postmortem studies, whether the hypothesis that the primary lesion is a loss of isodendritic cells is correct.

Introduction

Biochemical analyses of postmortem brain tissue have yielded valuable information on the pathophysiology of several neurological and psychiatric disorders. In particular, the demonstration of a reduced concentration of dopamine in the corpus

striatum of patients dying with Parkinson's disease¹ has led to the development of levodopa treatment. The loss of striatal dopamine is the most prominent biochemical abnormality in Parkinson's disease, but there is also a loss of subcortical noradrenaline.² The losses of dopamine and noradrenaline accord well with the histological observations of losses of brain-stem pigmented neurones.³ Areas of loss include not only the substantia nigra (the origin of the dopamine nigrostriatal pathway) but also the locus coeruleus (the origin of the noradrenergic innervation of the forebrain).

Several studies have shown deficits in specific neurotransmitters in Alzheimer's disease. The most prominent abnormality is the reduction in the activity of choline acetyltransferase, the biosynthetic enzyme for acetylcholine, in the cerebral cortex.⁴⁻⁷ Since the cerebral cortex contains few, if any, intrinsic cholinergic neurones,⁸ this loss of choline acetyltransferase activity reflects a loss or dysfunction of ascending cholinergic projections.^{7,9} The origin of the hippocampal projection lies in the septum, and the origin of most of the cholinergic projections to the neocortex seems to be within the substantia innominata.⁸ As well as the reduction in cortical choline acetyltransferase activity there is also a loss of cortical and subcortical noradrenaline¹⁰ and of cortical dopamine- β -hydroxylase activity.¹¹ These observations seem to provide the biochemical correlate of the observed loss of cells from the locus coeruleus in Alzheimer's disease.¹²⁻¹⁴

Loss of ascending projections

These biochemical studies point to a similarity between Parkinson's disease and Alzheimer's disease in that they both show a loss of ascending projections. This loss predominantly affects the dopaminergic striatal projection in Parkinson's disease and the cholinergic cortical projection in Alzheimer's disease, but both diseases also show a loss of the noradrenergic projection from the locus coeruleus. This similarity is further

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