Malawi clinical officers and a volunteer doctor from the UK dealt with 407 patients presenting with a full range of tropical diseases seen in Central Africa, including those targeted but as yet not reached by the listed Global Fund vertical programmes. The fact that the children's parents/guardians will travel for up to 2 days to be seen by our team indicates their lack of alternatives. Vertical programmes will never reach these children.

We have expanded our programme to include a mobile operating theatre for minor surgery in the field, vaccines to support the national immunisation programme, antiretroviral drugs (ARVs) for PLWA children (children under 13 years of age with AIDS were initially excluded from the Malawian ARV roll out) and in partnership with UNICEF, an initiative in the prevention of mother to child transmission of HIV through prophylactic ARVs and exclusive breastfeeding for the first 6 months of infancy.

A key part of our work is integrating care with other healthcare providers, making cost-effective primary health achievable. Those diagnosed with conditions requiring specialised treatments have their transfers facilitated without the need for other levels of bureaucracy.

Our experiences persuade us that this form of primary health care is the most effective use of donor money.

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Authors' response

We thank Dr Burt for his comments and would like to compliment him on his response towards the population's need in precedence over the pursuit of the vertical programme. In fact his experiences underscore the point we make: the importance of comprehensive, horizontal primary care for population health. Burt, in an elegant way, has merged the horizontal and vertical approaches, by using facilities of the AIDS programme to improve overall care in the community. In our view, this should be approached in a structural way, by running disease-specific programmes through community-based primary care, and investing a small part of the programme money to strengthen the structure of integrated, horizontal primary care.

Dr Burt's comments stress also the point of durability. His impressive example demonstrates what highly trained and motivated GPs can achieve even when modest extra resources are made available to primary care. The training of GPs and other primary care providers in the community, and at the same time investing in their ability to provide care, is in all probability the best way to guarantee access to care where it is most needed: out, in the community.

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Appraisals

I am an ordinary jobbing GP in a non-training practice focused on delivering a good service to my patients. I find the current appraisal system irksome rather than helpful and so I turned to the article in the February 2008 issue[1] with interest.

I am glad that someone is looking critically at the system but the background of the authors concerns me. Three out of the four authors are employed by or have close ties to the organisation involved in devising and implementing the system. I am sure that they are honourable people, but I think it may be difficult to be objective about a system to which you have devoted much time, energy, and emotion. The study was funded by the bureaucracy that stands to benefit by keeping it going. We rightly criticise drug companies for that sort of thing. Would we ask an architect to investigate why his radical new building collapsed? I would have preferred an independent research body such as the Kings Fund or similar.

The authors comment towards the end that the value of the process declines with repetition but that those GPs who found the first appraisal valuable continued to do so.

I would certainly support the first point. Large parts of my preparation for this year were simply cut and pasted from last year. As to the second point, perhaps the process should be voluntary and only for those who find it valuable? The percentages in Table 1 measuring the utility of appraisal against a broad range of descriptors show a poor rate of return for all the effort.

The only form of appraisal worth anything to me or my patients is to be measured against a clear set of accepted and evidence based criteria. Until they can be agreed and properly tested, leave me alone with my professional responsibility.

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DOI: 10.3399/bjgp08X279526

Corrections

In the February issue of the journal, the authors of the letter 'Sexual enquiry in older people' were ordered incorrectly, they should be Elizabeth Starren, Gareth Walker and James Warner.

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