

Fudan Journal of the Humanities and Social Sciences

Reconsidering the Barefoot Doctor Programme

--Manuscript Draft--

Manuscript Number:	FDHS-D-15-00054	
Full Title:	Reconsidering the Barefoot Doctor Programme	
Article Type:	Original Paper	
Funding Information:	European Commission Research Executive Agency (631344)	Dr. Xun Zhou
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Author Comments:	Nothing in particular	

Reconsidering the Barefoot Doctor Programme

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Acknowledgments

This paper is part of a larger research project “Between State and Community—Public Health Campaigns and Local Healing Practices in socialist Asia 1950-1980: Mao’s China, a case study”. I have received the Marie Curie Career Integration Grant (CIG) from the European Commission Research Executive Agency for this project. I wrote this paper during my time as a visiting scholar at International Centre for Studies of Chinese Civilization (ICSCC), Fudan University. I am grateful to ICSCC for providing me the environment to complete this paper. ICSCC also sponsored my research trip to Fuyang County in Zhejiang Province for which I am grateful. In addition, ICSCC provided generous support for the International Workshop “Old and New Paradigms of Public Health: Historical Perspectives and Global Challenges” (May 2015). This paper has benefited greatly from the conversations generated from the workshop. I am also grateful to the History Department at the University of Essex for providing me with the intellectual environment and essential support needed in order to carry out my research.

Reconsidering the Barefoot Doctor Programme

Abstract:

This paper examines the widely acclaimed Barefoot Doctor campaign in China. The Barefoot Doctor Campaign has come to symbolize the success of Chinese health care to the extent that it has become a model for WHO public health strategy. Yet little has been done to understand how or whether it worked on the ground and what difficulties and contradictions emerged in its implementation. Using previously unexplored party archives as well as newly collected oral interviews, this paper moves away from a narrow focus on party politics and policy formulation by examining the reality of health care at the local level and the challenges faced by local authorities and individuals as the campaigns evolved.

Key words: Healthcare delivery, Primary care, Barefoot Doctor, Rural Health in China, Local Practices.

Health and medicine has played a central role in the Communist revolution in China and the socialist construction thereafter. Long before the founding of the People's Republic of China in 1949, Mao Zedong and his comrades had begun to consider issues of population health. Disease and illness were depicted as the enemy of the revolution for it could weaken the efficiency of the Red Army. To reduce any wastage from disease it was necessary to carry out health and preventative measures. Furthermore public health campaigns were an efficient way for the party to manage the population in the communist controlled Soviet/Red base. Hygiene rituals and healthy diet were introduced as forms of discipline for both the army and the civilians of these regions.¹ After the Chinese Communist Party (CCP) took over China in 1949, medicine and health work grew more important politically. As in Western Europe, where public health developed from a concern for national economic and military efficiency, in the first years of the People's Republic of China, the development of medicine and public health services were understood as fundamental to the socialist state building linked to country's stability, productivity and military manpower. Furthermore medicine and health work opened the door for the party to introduce the new "socialist rationalization" to every sphere of life and thus to transform the "old" and "diseased" individual bodies into a socialist collective body or new men and women fit for the new socialist state. Official health programmes also allowed the party to build up medical and health administrations which would help the party to police the population at a micro level or to make them "governable subjects."

Despite their reported success, official public health programmes in the PRC have always stirred up conflicting interests at the local level. When these conflicts were

¹ "Investigation in Changgangxiang" in Collection of Mao Zedong's Writing, vol.1; also see <http://e-chaupak.net/database/webmao/html/mx01276.htm> (assessed on 4 August 2015).

1 significant enough they could cause the non-implementation or alteration of state
2 programmes. In addition, the changing politics in the PRC has often hampered the
3 implementation of these programmes, in some cases their abandonment. Furthermore,
4 the official effort to use medicine and health work to “change the prevailing social
5 customs” 移风易俗 was largely unsuccessful. Folk medicine and traditional healing
6 rituals remained a contested arena between the health authorities and the rural
7 population in different parts of the country throughout the Mao era. Their revival after
8 the death of Mao is therefore not surprising.
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10 My intension here is to move away from a narrow focus on party politics and
11 policy formulation by examining instead the reality of healthcare and medicine on the
12 ground. In this paper, by using previously unexplored archival documents and oral
13 history work, some conducted by myself and others by the research team at Institute
14 of Health at the Kunming Medical University and Yunnan Health and Development
15 Research Association, I will examine individual and group responses to state power in
16 the context of changing or lack of state’s provision of health related welfare following
17 the Great Leap famine in the early 1960s. As result of the government’s failure to
18 deliver the promised health related welfare, spirit exorcism and other collective
19 healing rituals, as well everyday practices (including remedies) in the domestic setting
20 emerged and reemerged to become a commonplace in the rural countryside. Ghosts,
21 spirits and vapours occupied different corners in everyday life under socialism. I
22 argue that to a great extent the Barefoot Doctor campaign, first launched in the mid
23 1960s, was the CCP’s effort to engage rather than to alienate these traditional/folk
24 elements. By examining the reality of healthcare on the ground and the challenges
25 faced by local authorities and individuals as well as the ongoing negotiations of these
26 local actors as the Barefoot Doctor campaign evolved, my aim is to bring out the
27 complex interface between local everyday health strategies and state provision or the
28 lack of state provision of both modern allopathic medicine and systematised
29 “Traditional Chinese Medicine” (as being taught in medical schools and practiced by
30 trained specialists). By focusing on how party policies from above were implemented,
31 circumvented or changed by villagers, health workers and cadres from below, we can
32 get a closer view of what life was really like for a whole range of complex individuals
33 struggling to cope with illness and disease in the aftermath of the worst famine in
34 history, and how state health ideologies were communicated, enacted, revised or
35 sometimes ignored. It shows that with the implementation of the Barefoot Doctor
36 campaign, individuals or communities incorporated governmental health program to
37 accommodate for local conditions or their own needs. In addition, folk healers
38 including witch doctors and exorcists co-existed alongside the barefoot doctors (most
39 of them operated on their own) to provide everyday health aid/care for sick villagers
40 through prayer, possession, community and domestic rituals.
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55 Post famine health crisis

56 From the end of 1961, as large parts of China struggled to recover from the
57 devastated famine, health delivery had become a setback for the CCP. Large parts of
58 the countryside, as well as many cities, were ravaged by disease. Edema,
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1 gynaecological problems and child malnutrition, known as the Three Diseases (三病)
2 were widespread. In Hunan's Xiangtan region, for example, in 1962 more than 5
3 percent of the local population suffered the Three Diseases, and the number was
4 reported to be on the increase each month (HN163-1-1126, 54-5). Similarly in
5 Sichuan, between January and July 1962, each month the number of people suffering
6 edema continued to rise. More than 60 percent of them also suffered other famine
7 related health problems, and about 20 to 30 percent of those died. Even in cities such
8 as Chengdu and Chongqing, child malnutrition and rickets were reported to be
9 prevalent (JC133-449, 107-8).²

12 Adding to the complication was schistosomiasis, a debilitating infectious
13 disease the CCP had been trying to eradicate since 1952 as the centrepiece to its
14 national public health campaign. Along the Yangtze River delta and the lake regions
15 are known as China's rice baskets. Here, paddy fields and the labyrinth of waterways
16 water provided fertile environment for snails, the carriers of schistosomiasis.
17 Historically, the disease had evoked widespread of fear in these regions. In 1949
18 when the CCP took over China, it was estimated that the disease was endemic to 11
19 provinces along the Yangtze valley and some of the southern coastal provinces. The
20 new CCP government thus saw the successful control of the disease was an effective
21 way to consolidate its newly gained power in these regions. The need for a healthy
22 and efficient army force in the wake of Korea War in 1952 as well as to improve
23 manpower economy in order to build a new socialist countryside also added to it the
24 political urgency. Yet the Party's eradication programme was regularly met with
25 contestations for complex cultural and socio-economic reasons. In the process of
26 implementation it was often altered due to variety of local pressures and difficulties. It
27 was further hampered by the Great Leap famine and as result the
28 Anti-Schistosomiasis campaign literally came to a halt between 1958 and 1961.

36 After 1961, in order to recover from the famine, government sent a huge
37 number of people, including students, workers, employees of government units and
38 soldiers to the countryside to support agricultural work. Unaccustomed to the
39 environment of the new place, many of them became infected with the disease. A
40 telegram from the Central Committee (CPC), dated in 1962, showing the disease had
41 spread to more than 50 counties in Anhui, Hubei, Jiangxi, Hunan, Jiangsu and
42 Shanghai. There were more than 10 thousand new cases reported in three counties in
43 Hubei province, and amongst them 300 acute infections for that year (JC133-449, 73).
44 A few months later in 1963 it was reported that schistosomiasis was prevalent in 42
45 counties in Jiangsu, and there were 6031 cases of acute collective infection. The
46 number of victims had increased more than 40 percent compared to the year before,
47 and 80 percent of them were prime labourers. As result there was no one to transport
48 the harvested grain and fight against draught (JC133-450, 31-3). While an increasing
49 number of people were dying from it, a huge number of oxen were also infected and
50 died (JC133-449, 73, 95). Fearing being infected, many people refused to work in the
51 paddy fields. In 1963 a team of Public Security soldiers were sent to support

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60 ² For English translation see Zhou Xun (2012), 52.
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1 agricultural work in Sichuan's Lushan County. 96 percent were infected with
2 schistosomiasis and one soldier died of it. "The leadership above only care about
3 production not human life," the remaining soldiers cried. Some even announced that
4 they'd rather be shot than step into the paddy fields (JC133-450, 34).

5 The CPC was anxious. Agricultural productivity was a key to China's
6 economic recovery. To improve productivity however required a healthy productive
7 labour force. Since millions had already been killed in the famine, the eradication of
8 schistosomiasis as part of an efficient healthcare system was understood as a
9 necessary measure to ensure no further casualties. The issues of controlling
10 schistosomiasis and an efficient healthcare delivery system became important not
11 merely because of the enormous wastage of man-power that diseases and poor health
12 caused during this time of national emergency, but they were seen as political tools to
13 enforce the socialist collective economy in the countryside as well as to ease the rising
14 tension between the CCP and the remaining rural population. In January 1964 at a
15 CPC meeting, Xu Yunbai, the deputy minister of health at the time declared that
16 Anti-Schistosomiasis campaign was an integral part of the socialist economy and "its
17 success is crucial to the improvement of the collective agricultural
18 productivity."(JC133-450, 62) The campaign was once more placed at the forefront of
19 the health work. But Xu's speech and the Ministry of Health's attempt to revive the
20 campaign was met with little enthusiasm on the local level. In Sichuan's Mianzhu
21 County, for example, local officials and villagers blamed the eradication campaign for
22 contributing to the famine: "We had spent many years eradicating the disease but in
23 the end we achieved nothing excepting for wasting labour and money." Some local
24 officials put it bluntly: "If you want to eradicate schistosomiasis, you send a team, but
25 we will have nothing to do with it." At the county level, the cadres used famine
26 recovery as excuse by saying: "Our problem now is to provide food and clothing for
27 people, schistosomiasis has to wait for a couple of years." Those assigned to take
28 charge of the eradication work compared themselves to "rats trapped in a barrel, being
29 bullied from both ends": "cadres don't support us, and villagers don't like us, how can
30 we carry out the work?" they grumbled (JC133-450, 2). Lack of financial resources
31 and manpower presented even bigger problems. According to an official estimate, due
32 to lack of funding, a huge number of state run Anti-Schistosomiasis units had been
33 dissolved and the work teams, including medical experts, had been reduced by half
34 compared to 1957. In the meantime, 80 percent of equipment had been damaged due
35 to lack of care (JC 133-453, 48-9). Many local officials and health workers lamented:
36 "Eradicating schistosomiasis is like trying to reach the stars in the sky, we will never
37 be able achieve it." "Our hair will turn white, and our teeth will fall out, but we will
38 never get rid of schistosomiasis."(JC133-454, 67)

39 Not only was the implementation of Anti-Schistosomiasis campaign weakened
40 by the financial and personnel difficulties, the lack of funding also injured health
41 work in general. The poor pay and working conditions as well as lack of support from
42 local officials also angered many health workers. In Sichuan, one of China's largest
43 agricultural provinces, 50 percent of commune hospitals were preoccupied with
44 treating edema, and they had no money left to pay staff or to purchase medicine.
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1 Hospital staffs lost motivation for any health work. Many state-run health services
2 had come to a halt as a huge number of employees were cut back due to lack of state
3 funding (JC133-449, 11). Equally dismaying was the rural health work in Hunan.
4 While local health workers complained about the lack of resources, cadres showed no
5 enthusiasm in supporting health work. In Henyang County's Chashi commune the
6 party secretary passed the health work responsibility on to the brigade head. Like in a
7 basketball match, the brigade head simply turned around and passed it to the section
8 head of the local Women's Federation. But the response he got was equally negative:
9 "Health work was a losing activity last year, and there is no way I am going to take it
10 on again." As more than 40 percent of the communes in Henyang could not come up
11 with the money to pay local public health and medical personnel, they were faced
12 with the danger of job cuts. Unsurprisingly, they lost all interest in doing any health
13 work (HN163-1-1126, 54-5). In Hebei's Tong County, a number of commune clinics
14 were shut down because the commune had no food to feed their staff. Frustrated,
15 these medical and health staff threatened to leave and open up their own private
16 practices. In other parts of the country a huge number of medical staff in state run
17 health institutions also left and opened up private practices where they could charge
18 high prices (JC133-123, 16; BJ135-1-1368, 37). Those who had means migrated to
19 Hong Kong, others with power stayed on using their job to extract extra food and
20 money (JC133-174, 29). A number of counties in Sichuan, state-run hospitals and
21 health units turned to the narcotic black market where medical personnel regularly
22 prescribed morphine and other opiates for each other. The drugs were subsequently
23 sold at a high price to those newly opened private practices or used for bribery
24 (JC133-123, 1-5). Corruption, profiteering and abuse were so widespread that it
25 prompted the Ministry of Health to take drastic action to rectify the health work at the
26 grassroots level (JC133-174, 29; BJ 135-1-1368, 3).

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36 In the meantime to reduce the burden on food supplies in cities and towns,
37 millions of urban residents were sent down to the countryside, amongst them were
38 many medical practitioners who worked at integral polyclinics. Although in theory
39 they were called peasant-doctors (半农半医) and allowed to practice medicine, in
40 reality, however, most of them gave up their medical work as it did not earn them
41 work points. Without work points they would not receive any food (YN120-1-224,
42 62-3).³ Even many practitioners stayed in the cities were also forced to give up
43 medical work since the polyclinics where they practiced were shut down.

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47 The lack of healthcare contributed to the increasing popularity of collective
48 healing rituals as well everyday ritual conducted in domestic settings. According to an
49 investigative report of Yunan Provincial Party Committee, in Chuxiong county at
50 least 117 villagers from eight different communes were making a living by practicing
51 "superstitions". Collective rituals such as exorcism or sorcery involving a large
52 number of people were a regular feature of village life. Popular supernatural rituals
53 were by no means limited only to villagers. A number of cadres and party members in
54 Chuxiong were reported to have taken part in supernatural healings. In one commune,
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³ For an English translation of this document see Zhou Xun (2012), 111.

1 when the wife of a local cadre became ill, she sent for a diviner to read her fortune
2 instead of being treated by doctors. Even more worrying was that “superstitions had
3 been revitalised as a growing number of people became apprentices to these
4 traditional elements,” and “majority of people take these superstitions very
5 seriously.”(YN 120-1-224, 61-2)⁴ Closer to Beijing, an official report estimated more
6 than 50 thousand practicing wizards, witches and fortune tellers in Hebei province.
7 Here too many party members and cadres took the lead in “superstition activities.”
8 (Qian Xiangli, 294) Unsatisfied with their work conditions and low pay, faced with
9 uncertainty and enormous pressure, health workers of some government units also
10 sought protection from Buddha, spirits or diviners (JC133-174, 33-4).

11 The low standard of healthcare in the countryside on the other hand led some
12 villagers to question the professional competence of health professionals and the
13 reliability of state healthcare delivery as we saw the response to the
14 Anti-Schistomiasis campaign. A report from Sichuan Provincial Bureau of Health and
15 Hygiene states that after 1961 the implementation of health and medical work
16 amongst subaltern groups in rural Sichuan was confronted with increasing number of
17 obstacles. In state run hospitals, the number of outpatients and inpatients had
18 decreased drastically. Many villagers even refused to be treated by governmental
19 mobile medical teams. In contrast, lamas and shamans were high in demand
20 (JC133-173, 37).

21 Another issue was the withdrawal of free medical care in these regions after
22 1961. Prior to 1950, subaltern groups in the southwest (being classified as ethnic
23 minorities under the CCP) had only intermittent contacts with modern allopathic
24 medicine (this was also the case for majority of rural Chinese population). In the early
25 1950s, free medical care using modern allopathic medicine was a key strategy the
26 CCP employed to gain support from the lower and middle stratum of the society in
27 these so-called minority regions (JX1-865, 77, 80; JX1-851, 6-8). As result medicine
28 became a crucial thread which bound the local population to Mao and the CCP. For
29 example, in Angla (in today’s Qinghai) after the CCP medical team cured her illness,
30 a 60-year-old woman was convinced that Chairman Mao was more powerful than the
31 Sangji Lama. Also being cured by the CCP doctors, another Tibetan woman recited
32 sutra while holding Mao’s portrait over her head (JX1-879, 23-4). For these villagers
33 Mao came to represent a new power on the top of the religious hierarchy of their
34 world.

35 The initial success of allopathic and free medicine in curing illness as well as
36 the repeated government health education campaigns had built up the expectation
37 amongst the local population for adequate state provisions to protect them against
38 illnesses, and medical care in the event of them falling sick or the occurrence of a
39 disease outbreak. In 1961, however, due to lack of financial resources the free medical
40 care was withdrawn and a pay-for-treatment system was introduced in these regions.
41 In this new system the patient had to pay the total or part of the costs. Since most
42 people in these regions were economically worse off than the rest of the country, they

4 For an English translation of this document see Zhou Xun (2012), 111.

1 simply could not afford going to hospitals for checkups or treatment. This, as well as
2 the low standard of care, was perceived by the local population as the CCP's failure to
3 fulfill its obligations as the new ruler. They no longer trusted the state run health
4 delivery service, and brought their health concerns, as well as other troubles, to the
5 lama and bimo (the shaman priest of the Yi) as they had been doing previously
6 (JC133-173, 37).
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8 The CPC was also alarmed by an increasing amount of disturbances in the
9 countryside heralded by rumours including outbreak of diseases and abuses in
10 hospitals. In parts of Guizhou many villagers who contested collectivisation in the
11 first place felt even greater resentment towards the CCP after the famine. They used
12 collective ritual meetings, often involving healing, to recount the harshness of the
13 CCP rule and the hardship they had endured. Rumours such as "the son of heaven is
14 coming" and "Chairman Mao has only two more years to rule the country" were
15 disseminated through these meetings. In the meantime sectarian movements such as
16 the Guanyin Laomu Dao sect, which the CCP had tried hard to suppress, became
17 evermore active and had successfully recruited over 1200 new followers (Chishui 1-
18 A14-15, 38). In Hebei too, more than 8000 sectarian activities were reported (Qian
19 Xiangli, 294).
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22 The authorities were faced with the dilemma of what to do. Previously
23 sectarian movements and disturbances were suppressed as "counter-revolutionary"
24 activities. This often led to further alienation which had already been happening in
25 parts of the country. In Yunnan, for example, collectivisation in 1956 had caused a
26 number of disturbances involving collective rituals amongst the mountain dwelling
27 Yao people. At the height of collectivisation in 1959, the Yao villagers were forced to
28 move down from the mountain to the fertile plain to carry out agricultural work.
29 Unaccustomed to farming, the strange climate and environment, many became ill. For
30 these Yao villagers, as well as many other rural populations in China, disease and
31 illness were understood as a sign of contamination and "ghost affliction."
32 Traditionally many approached it by escaping or exorcism. In the early 1960s these
33 Yao villagers moved back to the mountains where they performed the collective ritual
34 of sorcery dances to expel the evil spirit or disease in this case. The local authority
35 responded with hard line suppression which only led to estrangement. These Yao
36 villagers cut off all communications with the authority (YN 120-1-224, 84).
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46 The lesson of the Mashan incident in 1956 on the other hand suggested there
47 was a better way than suppression of handling disturbances. Situated in Guizhou,
48 Mashan is a mountainous region with a diverse ethnic population. Dissatisfied with
49 government's grain procurement policy and collectivisation, these villagers engaged
50 in collective rituals which led to military uprising involving thousands of people and
51 lasting over ten months. At the time the local government was widely divided on how
52 to handle the disturbance. While the majority insisted on military suppression, a small
53 number advocated peaceful resolution. In the meantime the CPC called to re-examine
54 the ethnic policy in China. At local level, officials responded to this differently. In
55 Guizhou the local party committee quickly began to re-organise the regional ethnic
56 policy. As a result, they turned away from the earlier suppression policy and issued an
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1 emergency instruction to resolve the disturbance by peaceful means. To “comfort” (抚)
2 the villagers, medical teams were sent to Mashan where more than 3,750 people were
3 given free treatment within a day. This emergency instruction by Guizhou provincial
4 party committee was subsequently passed on to local party committees in Xinjiang,
5 Sichuan, Gansu, Qinghai, Yunan and Tibet as a guideline for handling future
6 disturbances in these regions (Wang Haiguang, 43-54). A little over a year later at a
7 national minority conference, the CPC declared that the religious freedom amongst
8 the ethnic minorities should be the long term policy and “we must handle religious
9 matters carefully in according to people’s actual need for religious life. We should
10 allow people to continue their religious activities.” In 1961, supported by the CPC,
11 more than 137 lama temples were re-opened in Qinghai, and more than 380 religious
12 leaders were allowed to practice (Qian Xiangli, 217-8).

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17 In time of national emergency after the famine, sensitivity to the needs of
18 peasants (both ethnic and Chinese), who were bulwark of the CCP’s power in the
19 countryside, was politically essential to the party. Instead of suppression, medicine
20 and health work was used as a political tool to “comfort” villagers, thus to ease the
21 tension and to bond millions of villagers to the party. In 1964, in a draft proposal for
22 the future hospital work, the Minister of Health Qian Xinzhong proposed for a revival
23 of “revolutionary humanitarianism” using the example of the military hospitals.
24 According to him, between 1960 and 1961 more than 4000 health workers from
25 military hospitals were sent to the countryside to provide medical and healthcare to
26 the rural population: “their revolutionary humanitarianism won the high praise of
27 villagers. [...] villagers referred to [...] the military hospitals as “life saving.”
28 (JC133-174, 32-3).

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33 In addition to “revolutionary humanitarianism,” health work could be further
34 politicised and incorporated into the mass political campaign – the Socialist Education
35 campaign – which was currently underway in the countryside. In 1963, the Ministry
36 of Health urged health authorities in different parts of the country to begin the
37 re-organisation of rural health work linking it to the Socialist Education campaign
38 (BJ135-1-1368, 3; JC133-173, 14-21). Disease and illness were depicted as the
39 “enemies from the nature world” who were the aide and allies of political enemies:
40 “To build the new socialist countryside is to fight our political enemies and diseases,”
41 Xu Yunbai says, and to control schistosomiasis was to promote socialist
42 consciousness for it helped “to change the prevailing social customs.” It was thus
43 believed that schistosomiasis as well as other aspects of health work should be a core
44 content in the mass political meeting “to recount the suffering of the old society and
45 to mediate on the present happiness” (忆苦思甜) (JC133-450, 64).

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51 Mass meetings were nothing strange to the rural population in China. Festivals,
52 collective rituals and operas were integral parts of social life in the countryside prior
53 to the Communist rule. They often served the purpose of disseminating miraculous
54 tales of healing and devotion at the local level, thus facilitating social cohesion
55 (Overmyer, 100; Doolittle, ch. V). Just as *yangge* or “rice planting song”— a popular
56 performance in rural northwest China — was adopted by the CCP in Yan’an in the
57 1940s to disseminate the message of revolution and socialist image (Chang-tai Hung,
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82-99), local festivals and collective ritual meetings were transformed into mass political meetings where tales of illness and disease suffered in the “old China” were contrasted to party’s care for the people in the “new China” was said could “arouse people’s affection for the party”, thus unite the people with the party.

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Franchising rural healthcare

The question was how to carry out rural health work in the countryside? One of the problems was, and still is, public health policies were designed by health experts and officials from above. Most of them were trained in elite medical schools in China or overseas. They viewed rural villagers as inherently ignorant, backward thinking, unhygienic and diseased. As with all policy entrepreneurs, they were professionally and politically ambitious, but they had little understanding of or interest in the health needs of the rural masses. An investigative report from Sichuan’s Langzhong County, dated in 1965, pointed out that the plan to build more rural hospitals and polyclinics was not only economically not viable, it was also not what the rural population wanted. Far from being ignorant, the report shows that the villagers were fairly capable of making informed decisions: “They prefer herbal medicine and they always decide on which doctor to see.” More importantly “villagers want what’s cheap and works.” (JC 133-1771, 92-3).

Furthermore, the high standard of care available at the flagship hospitals in Beijing and other big cities also raised the expectations that could not be met elsewhere, particularly in the rural countryside. There were constant complaints about the lack of healthcare, the low standard and high price. “There have been political and economical improvements, and production has increased, but we have no place to go when we are ill;” “If we became sick and go to hospital, we will have to pay lots of money and we will never be able to *fansheng* (stand up or have better life).” (JC 133-46, 16-8) Due to lack of funding, the polyclinic in Sichuan’s Suining County only treated villagers who could pay. Doctors prescribed medicine not in accordance to the symptom but the amount of money the villager could afford. One elderly villager died as result. The clinic also manufactured their own medicine and charged high prices. According to an investigation, villagers spent average of 25% of their income on treatment and medicine. “Each treatment costs more than 10 kilos of sweet potato, how can we afford it?” they complained (JC 133-1771, 114-6).

With no patients, a number of rural polyclinics in Sichuan’s Nanchong County had no revenue and they had to pay the staff with medicine instead (JC 133-1771, 81-2). As communes and brigades were told to find their own money to finance the commune hospitals and clinics, they sent all sick people to the county or city hospitals for free medical care. As result, county and city hospitals suffered chronic overcrowding, overworked staff and financial difficulties. Most of them survived on loans (JC 133-1771, 1-2).

Lacking funding, a huge number of polyclinics and state run hospitals in counties and communes were facing the danger of being closed down. Since the early 1950s, the socialist healthcare system along with the socialist economy had been an integral part of the construction of socialism. The socialist economy demanded that

1 private doctors and folk healers to join the integral polyclinics. But as these clinics
2 were closing down, rural healthcare would have to be privatised, and this would
3 further jeopardise the socialist collective economic system that had already been
4 under threat as result of the famine.

5 In addition, rural health in Mao's China was more than just management of
6 sickness and disease. A big part of public health work in the countryside, the
7 Anti-Schistosomiasis campaign for example, was environmental health. It consisted
8 of managing human and animal night soil (feces used as fertiliser) and water, both
9 essential to farming and thus intrinsic to the rural socialist collective economy. After
10 the famine, a household quota system (包产到户) was introduced in different parts of
11 the country and there was a big push to allow individuals to keep private plots. As
12 many villagers fought to keep their private plots, they refused to hand over domestic
13 night soil to the collective so they could keep it for the private use (JC 133-453, 62).
14 In Sichuan's Dazhu County, for example, some villagers even threatened to sell their
15 bigger pigs, so they would not have night soil to handover, others added water to their
16 night soil to make up the quota (JC 133-459, 188).

17 Whether to replace the collective farming with the household quota system
18 was a sore point for Mao and the party leadership. The management of fertiliser as
19 well as water was thus crucial in this struggle. While affirming the political urgency
20 of public health work in relation to the management of night soil, at a national health
21 conference regarding schistosomiasis control, Liao Luyan, the minister for agriculture,
22 also acknowledged that "we cannot just give orders to 500 million peasants, it won't
23 work. We must convince them." (JC 133-453, 62). To convince the rural population
24 meant on the one hand to promote health and hygiene education, and on the other to
25 provide a cheap and adequate socialist healthcare that would appeal to and work for
26 them, so they would be committed to the socialist collective economy. Since a
27 centralised health delivery system was not affordable and could not work for such a
28 vast country, it meant healthcare and public health work in the countryside had to be
29 franchised while remaining part of the socialist collective economy.

30 The idea of franchising rural health service was further catalysed by a
31 conversation between Mao and his doctor Li Zhisui. On June 26 1965, in a
32 conversation with Li, Mao attacked the Ministry of Health for not providing
33 healthcare for the rural mass. "China has five hundred million peasants," he said, "our
34 hospitals have all sorts of modern equipment and technology, but they ignore the
35 needs of villagers." He then went on to talk about reforming the healthcare system
36 and the existing medical education. According to him, medical skills were learnt
37 through practices, thus the type of doctor for the countryside did not have to be
38 talented or well trained. He ended the conversation by saying "In medicine and health
39 work, put the stress in the countryside."

40 Interesting to note, although this conversation was not made public at the time,
41 it turned on the green light to decentralise aspects of the healthcare in the rural
42 countryside, which had already begun in some places. After his conversation with
43 Mao, the doctor drew up a memo and sent to the Ministry of Health and Peng Zhen,
44 the mayor of Beijing and a Politburo member of the CPC. According to the doctor
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1 that he had no idea this memo would become the famous “June 26 directive,” the
2 basis for decentralising aspects of the healthcare which led to the launch of the
3 nationwide Barefoot Doctor campaign (Li Zhishui, 420-1). Five years later, on June
4 26 1970, in the middle of the Cultural Revolution, Premier Zhou Enlai edited the
5 memo and sent to Wang Dongxing (Mao’s bodyguard) for Mao’s approval to publish
6 it. Mao gave it back to Wang and said “Don’t publish it yet, leave it for a later date.”⁵
7 Nevertheless back in 1965 upon receiving the memo, the Ministry of Health and
8 health bureaucrats were embarrassed by Chairman’s criticism. This was partly
9 because in June 1965, the same month of Mao’s criticism, the *China Medical Journal*
10 had just published a report by the Department of Medical Administration of Ministry
11 of Health boasting “epoch-making achievements” of hospital services in both urban
12 and rural China in the past 15 years. (CMJ 84:412-6).The memo obviously cancelled
13 out the “achievements”. The Ministry of Health was obliged to respond. On
14 September 4th, Qian Xinzong presented the Ministry of Health’s report on
15 “Regarding putting emphasis on rural health work” to Zhou Enlai and the CPC. A few
16 months later in December, the *CMJ* editorial confirmed that “public health authorities
17 and medical institutions in every part of the country are taking radical measures to
18 make medical and public health work face the
19 countryside.”(CMJ84:779-800)Accompanied the editorial was a fieldwork report by a
20 medical team made up of 30 doctors and nurses from Chinese Academy of Medical
21 Science and China Medical college. The report trumpeted the wonders of their
22 medical work in rural Hunan in the past few months CMJ 84:800-3).Subsequently at a
23 national health conference, Cui Tianyi, the deputy minister of Health, apologetically
24 admitted the rural health work was not in step with the new political and economic
25 “high tide” in the countryside, and he urged health authorities and health workers all
26 over the country not to miss the opportunity. “Health work is an integral part of
27 socialist revolution and socialist construction,” he pleaded, “we must use health work
28 to consolidate the fruits of ‘Four Clean Up’ campaign.” The way to do it, according to
29 Cui, was to build up a rural medical and health network, or a franchising system of
30 health delivery (JC133-461, 6-8).

31 To build a franchising system would involve a massive training programme.
32 Already in January 1965, following Chairman Mao’s earlier criticism of Beijing’s
33 “bureaucrats” hospitals and the speech on “*Training successors* for the proletarian
34 *revolutionary* cause,” the Ministry of Health had drafted a proposal including sending
35 medical teams to the countryside to support rural health work and the “Four Clean Up”
36 campaign, reforming the medical education and training more “rural health workers”
37 (农村卫生员). These rural health workers had to be from a politically sound family
38 background and had to have correct thoughts. They had to be from the countryside
39 and nominated by the commune or brigade. After a short period of training, they
40 would return to the countryside where they would continue the agricultural work as a
41 member of the commune, and they would receive work points not a state salary for

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⁵ *The Chronology of Mao Zedong’s Thought: 1949-1976*, Vol. 5, 506.

1 carrying out health work.⁶ In another words, they would not become a financial
2 burden for the state. In the meantime Sichuan province had already gone ahead with
3 rural health workers' training. While the provincial health bureau sent out a
4 suggestion regarding establishing part-time Chinese medicine schools, one commune
5 in Neijiang County had started a Sunday training class for "after hour health workers
6 (业余卫生员)."(JC 133-1771, 36-7). Interestingly the training curriculum used in
7 Sichuan was remarkably similar to the training curriculum proposed by the Ministry
8 of Health three months later. The latter was sent out to local health authorities and 40
9 medical higher education institutions all over the country and adopted as a national
10 curriculum. The training was aimed at equipping each rural health worker to carry out
11 first aid, acupuncture and preventative medicine. The latter included recognising most
12 common parasites and diseases, and giving vaccination as well as the managing night
13 soil and water. In addition they would also study Chairman Mao's selected works and
14 current political affairs. This was to ensure they would be politically equipped to act
15 as the party's agents who would help the party to manage the rural population on the
16 micro level in addition to implement public health campaigns such as the
17 Anti-Schistosomiasis campaign. In this respect there is remarkable similarity between
18 this health training programme and the goals of the old Imperial examination system.

19 After 1968, these rural health workers became widely known as "barefoot
20 doctors" and this 1965 proposal became the template for training barefoot doctors.
21 The idea of a rural health network and health worker was, however, nothing new.
22 Already in the 1930s, in collaboration with John Grant from the Rockefeller
23 foundation and Jimmy Yen of the Rural Construction movement, Chen Zhiqian, the
24 doyen of public health in China, had begun a similar experiment in Hebei's Ding
25 County with the idea of transforming the "backward" Chinese countryside and the
26 image of the "Sick Man of Asia" through introduction of modern allopathic medicine
27 (Chen, Ch. 3). What Chen as well as other modernizing elites failed to understand was
28 the importance of folk remedies and "superstitions" in the life of rural population.
29 Contrary to modern western allopathic notion of medicine, traditionally for majority
30 of people living in rural China keeping health meant not to get ill. They viewed
31 curative medicine as a form of magic (Hsu, Francis, 66-72). It had little to do with
32 health. Going to a doctor was the last resort. Like the shaman and sorcerer or other
33 local spirits, the doctor was seen as the one who possessed magic power or the 36
34 methods (三十六术) which could bring the dead back to life.⁷ More than 30 years
35 later, little had changed. Despite the party's best intentions as well as the medical and
36 public health experts' concerted effort to transform the "dirty, diseased and backward
37 thinking" countryside through various public health campaigns, "superstitions" and
38 folk remedies persisted and continued to provide for the everyday health needs of the
39 people. Mao understood this, however. On August 2nd 1965, in a conversation with
40 Qian Xinzong and Zhang Kai from the Ministry of Health, he brought up the topic of
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57 ⁶ *Manuscripts by Mao Zedong since the founding of the PRC* vol. 11, 318-19.

58 ⁷ The idea of "bring dead back to life" could be find in Daoist text 《女仙传 太玄女》 as cited in 《太
59 平广记》. The immoral goddess was said to have learnt 36 magic which could bring dead back life.
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1 “magic medicine” (神医) . “Magic medicine has three advantages: firstly it’s safe. It
2 won’t poison anyone. Secondly, it’s cheap, it only costs a few copper. Thirdly, it’s
3 comforting and people will feel better afterwards.” He said.⁸ It would be wrong to
4 suggest Mao was promoting magic medicine here. What he presented to the Ministry
5 of Health was the formula: affordability and efficacy, as echoed in his earlier
6 conversation with his doctor: “They [rural health workers] would still be better than
7 witch doctors and quacks. Besides this is the only type of doctor the countryside could
8 afford.”⁹ Two days later, Mao’s conversation regarding “magic medicine” was
9 circulated at a national conference regarding medical education in the countryside. It
10 was interpreted in different ways on the local level. To some extent it helped to
11 preserve herbal remedies and other existing healing traditions in the countryside.
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15 More importantly, one central aspect of the Barefoot Doctor programme was
16 that the initial training only consisted of introducing very basic preventive medicine
17 and acupuncture as well as first aid. The assumption was that barefoot doctors would
18 continue to learn through practice. This allowed them the freedom to embrace the
19 existing local healing traditions. For example, Li Wangcheng from Shandong says
20 that after he became a barefoot doctor, he went around his village collecting folk
21 remedies. “There was no western medicine. I used only herbs, acupuncture, massage
22 and hot cups. [...] folk remedies were the main thing. I treated people with a needle
23 and herbs.” Li recalls.¹⁰ Zhang Chongling, from Yunnan, says that he treated
24 villagers mainly using secret recipes passed down from his family.¹¹ Li Ming, also
25 from Yunnan, recalls that he regularly went up to the mountain and studied different
26 herbs.¹² In Yunnan’s Ninglang County’s Alulaha’s commune, the training for
27 barefoot doctor was given by villagers who had some knowledge of herbal
28 remedies.¹³ Dun Huizhen, a barefoot doctor from Yunnan’s Xishan, was taught
29 Tibetan (not Chinese) herbal medicine by an army Tibetan doctor.¹⁴
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36 In addition to herbal remedies, witch doctors, sorcerers and other ritual healers
37 too continued to operate alongside the barefoot doctors. Liu Changzai, a former
38 barefoot doctor from Shanxi province’s Qin County recalls that he regularly met
39 together with the village witch doctor at homes of sick villagers. “She did her stuff,
40 and I did mine. We did not interfere with each other. At most we might take a look at
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46 ⁸ “Comrade Qian Xinzhong’s Speech regarding Chairman’s Instruction at the National Rural Medical
47 Education Conference on August 4, 1965”, from Conference Documents from 1965 National Rural
48 Education Conference, unpublished material.

49 ⁹ *The Chronology of Mao Zedong’s Thought: 1949-1976*, 505-6.

50 ¹⁰ “I was Forced to Become a Barefoot Doctor” in *From Barefoot Doctors to Village Doctors*.

51 ¹¹ “I treated Peng Dehuai with Chinese Herbal Medicine” in *From Barefoot Doctors to Village
52 Doctors*.

53 ¹² “I am the father for forty kids” in *From Barefoot Doctors to Village Doctors*.

54 ¹³ “I am honoured to have been a Barefoot Doctor” in *From Barefoot Doctors to Village Doctors*.

55 ¹⁴ “The Female Barefoot Doctor from the Shore of Dian Lake” in *From Barefoot Doctors to Village
56 Doctors*.

1 each other.” He says.¹⁵ Zhang Chongling, a former barefoot from Yunnan who
2 boasted to have treated Peng Dehuai, also admits that witch doctors and sorceress
3 practiced alongside of barefoot doctors: “In the countryside, they never stopped
4 practicing. Villagers believe in them,” he says.¹⁶ Another barefoot doctor from
5 Zhejiang’s Fuyang County agrees: “After the Barefoot Doctor programme was
6 introduced, those villagers who were followers of Buddhism continued to bow to
7 Bodhisattva. That’s what they believe.”¹⁷ On occasion, in particularly with child birth,
8 villagers would refuse the barefoot doctor’s advice, and instead they would instruct
9 the barefoot doctor to follow traditional birth rituals.¹⁸

12 Many barefoot doctors were aware that they were different from witch doctors,
13 exorcists and other ritual healers, even though they sometimes competed for business
14 or villagers’ affection;¹⁹ for villagers, however, they were simply another healer. “I
15 don’t understand what’s different about the barefoot doctor. I only know they are
16 from our village. It’s convenient to have them.” One villager from Shandong province
17 says.²⁰ Being simply another villager, the barefoot doctor, unlike the doctors from
18 hospitals or the government medical teams, did not tell fellow villagers what was the
19 right medicine or path to healing for them. Just as with other traditional healers, in
20 most case they offered their service when villagers called on them. Quite often
21 villagers would seek help from the barefoot doctor as well as the local witch doctor or
22 the exorcist or the herbal doctor for extra insurance. For these villagers, convenience,
23 affordability and efficacy, were the most important. Equally important was that the
24 barefoot doctor was someone to be trusted. He or she lived in the village, and
25 understood the local worlds and the values embedded in them which were otherwise
26 alien to the outsider. Not only the barefoot doctor as the caregiver was able to
27 communicate with those villagers – the receiver of such care – in a language they
28 would understand, the barefoot doctor was always there when needed and was willing
29 to spend as much time with villagers. Liu Wanping was a barefoot doctor from
30 Shanxi’s Qin County, “I slept at the health station, so I could be available when
31 villagers needed me. [...] It wasn’t hard work for me. I took on the job because
32 villagers trusted me. [...] When I saw villagers cry, I became very anxious. I feel for
33 these people. Their problem was mine too. I wanted them to trust me.” He says.²¹ In
34 the other side of China near the Korean peninsula, a villager from outside of Qingdao
35 remembers: “Because the barefoot doctor was in the village, if I had problem I’d go to
36 see her. If she could sort out my problem, that’s great. Since we had no money, and I
37 had nowhere else to go, it’s good to have her around. Day in or day out, we saw each
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51 ¹⁵ “A Barefoot Doctor and a Witch Doctor” in *From Barefoot Doctors to Village Doctors*.

52 ¹⁶ “Why do I think the Barefoot Doctor was Different from the Ordinary Peasant” in *From Barefoot*
53 *Doctors to Village Doctors*.

54 ¹⁷ Interviews with Doctor Xu, Fuyang county in Zhejiang Province, April 28, 2015.

55 ¹⁸ “A Turning Point in my Life”, in *From Barefoot Doctors to Village Doctors*.

56 ¹⁹ “A Barefoot Doctor and a Witch Doctor” in *From Barefoot Doctors to Village Doctors*.

57 ²⁰ “A Barefoot Doctor and a Witch Doctor” in *From Barefoot Doctors to Village Doctors*.

58 ²¹ “I Never Regretted for Being a Barefoot Doctor” in *From Barefoot Doctors to Village Doctors*.

1 other all the time. She was always approachable and pleasant, and she was honest if
2 she could not solve my problem. After all it doesn't really matter if she could not
3 solve my problem because she was helpful to me. I wish the doctor today would be as
4 kind hearted and less obsessed with making money.”²²

5 In small rural villages where virtually everyone was a friend, neighbour or
6 relative, to win their trust and respect was vital to many barefoot doctors. He
7 Yongjing from Yunan's Nanhua County says that he wanted become a barefoot
8 doctor because he wanted to be respected by villagers: “In our village, the doctor is
9 the most respected person. [...] Whenever a villager slaughtered a pig, they'd invite
10 me for dinner. [...] When villagers have difficulties, they'd always talk to the barefoot
11 doctor.” He says.²³ Liao Zuisheng from Jiangxi province's Xiajiang County on the
12 other hand says when he could cure a villager's illness he felt he had achieved
13 something and that made him happy.²⁴ Han Baisheng a barefoot doctor from
14 Shandong says that although he did not earn much at the time, he felt proud of being
15 a barefoot doctor for it indicated he was more capable than being an ordinary
16 farmer.²⁵

17 Furthermore, in the close community setup, dishonesty was not socially
18 acceptable, so the barefoot doctor would not dream of cheating or over charging
19 which has become a problem with marketisation. “Today, there are so many
20 medicines on offer. They just want to fool us in order to get our money. In the old
21 days, Shimeng [barefoot doctor] would give us some herbs, it was cheap, and it
22 worked.” One village patient from rural Shandong speaks fondly of the barefoot
23 doctor from his village. For Liu Wanping, money was much less important than
24 winging the affection of his fellow villagers as he recalls: “Villagers liked me because
25 I always tried my best to help them. I never cared to bargain for money. Everybody
26 was poor, why should I bother about money? [...] I treated those villagers who could
27 afford it, and I treated those who could not. [...] At one occasion, I charged one old
28 villager less. It made her very happy. After that, she would often ask for my help. We
29 were all poor at the time. I never wanted to charge villagers anymore than they could
30 afford.”²⁶

31 But the new rural health campaign was not carried out as smoothly as it was
32 portrayed in an overwhelming amount of state media coverage in China as well as the
33 accounts of western observers. In the process of implementation, what was on paper
34 was quite often altered to suit local interests. Some policy items were rejected outright
35 while others were abandoned as they proved impossible to implement. “There were
36 many papers from above concerning the Barefoot Doctor programme, but at the local
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52 ²² “Let's Talk about Barefoot Doctors” in *From Barefoot Doctors to Village Doctors*.

53 ²³ “Beijing a Barefoot Doctor Made My Dream Coming True” in *From Barefoot Doctors to Village*
54 *Doctors*.

55 ²⁴ “It made me Feeling Satisfied when I could Heal Villagers” in *From Barefoot Doctors to Village*
56 *Doctors*.

57 ²⁵ “Being Ordinary moves me” in *From Barefoot Doctors to Village Doctors*.

58 ²⁶ “I Never Regretted for Being a Barefoot Doctor” in *From Barefoot Doctors to Village Doctors*.

1 level, these papers were often ignored or being modified.” One former barefoot doctor
2 from Shanxi recalls.²⁷

3 There were also constant conflicts of interests at different levels. One barefoot
4 doctor in Shanxi complained about how doctors from county and commune hospitals
5 who were responsible for providing the training looked down on barefoot doctors like
6 him: “When they come, they would always criticise this and that. Once they were fed,
7 they would leave. They never explained what we did was wrong, and what’s the right
8 way to do it.” “Doctors in their 50s were often conservative. They didn’t want to pass
9 on their knowledge to people like me.” Before they’d teach him anything, he had to
10 make tea and cook for the doctors, as well as carry out the house cleaning. “Day and
11 night, [...] we barefoot doctor got the worst deal”, he said.²⁸ Zhang Rongcai, one of
12 the famous “10 sisters of Hainan”, had similar experiences while receiving her
13 training at the commune clinic: “We were given no opportunity to practice. All we
14 could do was to empty spittoons and clean the floor. After a while, there were only
15 three students out of ten left. We had to terminate our study as result.”²⁹ Wang
16 Guizhen from Chuansha County outside of Shanghai was China’s model barefoot
17 doctor. In 1974 she was invited by the WHO to speak to the Twenty-Seventh *World
18 Health Assembly* about China’s Barefoot Doctor programme. Even she spoke of the
19 struggles of being a barefoot doctor in a 1975 testimony: “[the experts in the hospital]
20 looked down on us. They constantly tried to block us and prevent us from prescribing
21 medicines. We were only allowed to keep 26 different kinds of most common
22 medicines in our medicine box. Once, a small child from our brigade suffered a lung
23 disease. I treated him and prescribed some medicine for him. But the hospital refused
24 to give us the medicine. It wasn’t because my prescription was wrong. It was because
25 I was a barefoot doctor.”³⁰

26 On the other hand, the lack of remuneration also deterred some barefoot
27 doctors from invest any enthusiasm in health work. A local cadre from a village
28 outside of Qingdao recalls: “Because there was no incentive, majority of barefoot
29 doctors were not proactive and they showed no interests in learning. For them it was
30 like being a monk in the temple who would go on tolling the bell as long as he is a
31 monk. The only time they’d show some enthusiasm was in front of cadres.”³¹

32 Even more problematic was the cooperative medical service (合作医疗),
33 which provided the framework for the Barefoot Doctors programme. In theory in the
34 cooperative medical service, each villager paid their share, and in return they received
35 free medicine and reimbursement in the instance when they had to be treated at the
36 hospital. But in reality, this was not always the case. First of all, the economic
37 conditions in rural China varied vastly from one location to another. In many of the

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27 “It made me Happy to see My Patients Healthy” in *From Barefoot Doctors to Village Doctors*.

28 “I Never Regretted for Being a Barefoot Doctor” in *From Barefoot Doctors to Village Doctors*.

29 “We are Barefoot Doctors at the Hainan Frontier” in *Barefoot Doctors Testimonies*. Vol.3, 89

30 “Learn the Theory of Proletarian Dictatorship and forever being the Carer of Poor Peasants” in
Barefoot Doctors Testimonies, Vol. 3, 44.

31 “Let’s Talk about Barefoot Doctors” in *Barefoot Doctors to Village Doctors*.

1 poor regions, even food and clothing was problem, villagers had no extra money to
2 put into the communal pot. There were 10 villages in Lowen Township situated in the
3 south of Yin Mountain in Shanxi province. Due to lack of water, the area had always
4 been poor. Since most villagers had trouble finding the money to pay their share, the
5 cooperative medical service could not be sustained. It would start and then stop. It
6 went on like that for a while. Although the cooperative medical service in former
7 barefoot doctor Sun Di's village in Shanxi province was chosen to be the model for
8 the area, their reported success was clearly an artificial one: "One year our village
9 were chosen as the model, the whole village had to get involved. The brigade sent us a
10 lot of medical equipment so we would look good." Sun Di recalls. In the end the
11 cooperative medical service had to be privatised. In order to continue providing health
12 services to the villagers, Sun introduced various charges.³² In Koutou village in Qin
13 County too, the cooperative medical service only lasted a year between 1969 and
14 1970. It ended because it was not economically viable.³³ In Shangdong's Daoguang
15 village, not all villagers received the promised reimbursement for medical treatment:
16 "It depended on who you were. Only those had a good relationship with the party
17 secretary could get the piece of paper which entitled him to claim the hospital fee
18 back. Ordinary villagers had no chance." One former village cadre remembered.³⁴ In
19 another village outside of Qingdao, the local cadre admits that unfairness or
20 corruption was a regular feature. Just as during the time of the famine that food
21 became a weapon and the serving spoon read faces, because medicine were scarce and
22 unaffordable, only those with "face", in other words, those who had a good
23 relationship with local cadres or the barefoot doctor had access to them. In this
24 particular region, as most of local barefoot doctors were chosen because they had
25 good relationship with local cadres, so they were more eager to serve the local cadres
26 and less so towards ordinary villagers. Villagers regularly complained about having
27 no access to medicine or good medicine.³⁵

28 Additionally, due to lack of experience and money, many village cadres were
29 incompetent or had no interests in managing barefoot doctors and the cooperative
30 medical service. "Most village cadres had little education, and we had no experience
31 in health work. We were simply trying it out. We had not anticipated many issues. We
32 only dealt with them when they caused problem. Most of them were badly dealt with.
33 There were a lot of problems regarding how to manage money, equipment and
34 medicine as well as the quality control of barefoot doctors. Maybe that's why the
35 cooperative medical service collapsed," one cadre from Shanxi province's Shiling
36 County reflects.³⁶ Not far in Qin County, the local cadres there used the village fund
37 for other purposes, so there was no money left to spend on the cooperative medical

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32 "It made me Happy to see My Patients Healthy" in *From Barefoot Doctors to Village Doctors*.

33 "The Barefoot Doctor who Treated Sick Villagers with Local Methods" in *From Barefoot Doctors to Village Doctors*.

34 "It made me Happy to see My Patients Healthy" in *From Barefoot Doctors to Village Doctors*.

35 "Let's Talk about Barefoot Doctors" in *From Barefoot Doctors to Village Doctors*.

36 "Swallow from the Tianjia Mountain" in *From Barefoot Doctors to Village Doctors*.

1 service. In the end they even deducted the barefoot doctor's work points, leaving him
2 and his family with no food. As result the barefoot doctor left, and the cooperative
3 medical service fell apart.³⁷Zhang Chongming a former barefoot doctor from Nanhua
4 County in central Yunnan is more condemning about cooperative medical service all
5 together: "It's nothing more than bragging. It's a dead ally. There was no funding
6 from the government, and villagers did not see the point. With no revenue, it
7 gradually fell apart."³⁸

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10 Despite all the complications, barefoot doctors like Wang Guizhen, Zhang
11 Rongca, Sun Di and many others prevailed. By 1975, according to an official estimate,
12 there were 1.8 million barefoot doctors in China (*China Reconstruction 30*: 69-71).

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14 Many barefoot doctors did provide invaluable healthcare or aid for millions of
15 villagers in the rural countryside. Contrary to the conventional portrayal, however,
16 their perseverance was not always driven by the policy from above or their
17 revolutionary zeal – some barefoot doctors did not even know that the Barefoot
18 Doctor programme was a government policy and the success varied from one barefoot
19 doctor to another determined by multifaceted factors.³⁹ For a number of individual
20 healers, the Barefoot Doctor progamme made it possible for them to continue to
21 practice under the framework cooperative medical service. He Yongjing is a Bai from
22 Yunnan's Nanhua County. His grandfather was a well-known herbal medicine doctor
23 in the village who had passed on his knowledge to He. Prior to becoming a barefoot
24 doctor, He had already been treating villagers. After one barefoot doctor in his village
25 resigned, the villagers nominated him. Being a barefoot doctor allowed his dream of
26 being a doctor to become true.⁴⁰ As with He Yongjing, Zhang Qichun from Shanxi's
27 Shouyang County had always wanted to become a doctor since he was 14. In 1968, he
28 was a secondary school student and the school was closed due to the Cultural
29 Revolution. In the meantime, the Barefoot Doctor campaign was launched in his
30 village. Zhang went to village cadres and asked to become a barefoot doctor. His wish
31 was granted because he had previously learnt herbal medicine from an elderly doctor
32 in the village and he had some education.⁴¹ Interestingly, in Zhang's case, he was
33 chosen not because of his political background as required by the central policy, but
34 because he had some education and knowledge of herbal medicine. This again
35 suggests that in fragmented authoritarian such as China policies from the centre were
36 regularly tailored to suit local circumstances.

37 38 39 40 41 42 43 44 45 46 Conclusion

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51 ³⁷ "I Never Regretted for Being a Barefoot Doctor" in *From Barefoot Doctors to Village Doctors*.

52 ³⁸ "How Village Doctors view the Cooperative Medical Service" in *From Barefoot Doctors to Village*
53 *Doctors*.

54 ³⁹ "The Female Barefoot Doctor from the Shore of Dian Lake in *From Barefoot Doctors to Village*
55 *Doctors*.

56 ⁴⁰ "Beijing a Barefoot Doctor Made My Dream Coming True" in *From Barefoot Doctors to Village*
57 *Doctors*.

58 ⁴¹ "Story of an Elderly Trainee Doctor" in *From Barefoot Doctors to Village Doctors*.

1 In the early 1970s, the Barefoot doctor programme or the “Chinese approach” to
2 healthcare, understood as a draconian government measure aimed to provide a ready,
3 convenient, inexpensive healthcare to 700 million Chinese living in the rural
4 countryside, became increasingly attractive to Western health professionals and policy
5 makers who were seeking a way out of the Western health crisis.⁴² Halfdan Mahler,
6 the new director general of WHO at the time and his colleague Kenneth Newell felt
7 strongly that the Chinese experience in tackling health problems with limited financial,
8 technological and human resources should be promoted around the world.⁴³ As of
9 1974, a number of barefoot doctors from around the Yangtze River region were
10 invited to speak at the World Health Assembly meeting and WHO regional meetings.
11 In 1975 Mahler proposed “Health for All”. It was adopted by the Twenty-Ninth
12 World Health Assembly in 1976 as its goal and was to be achieved by the year 2000.
13 Two years later in 1978, it was formally included in the Declaration of Alma Ata. Yet,
14 it seems ironic that at the time of the Alma Ata conference China, the leader of this
15 worldwide primary health care movement, began to gradually abandon the Barefoot
16 Doctor programme. It officially ended in China after 1983. As China began to
17 embrace neo-liberal market economy, and with the large scale of migration into
18 coastal cities, the government of China opted for a selective primary healthcare model,
19 and neglected local health needs. With emphasis on excellence, specialized healthcare
20 and focus on short term economic gain, millions of disadvantaged have been left out
21 of this process. Not only have they been deprived of healthcare, but also wellbeing.

22 As Tejada de Rivero, the deputy director general of WHO at the time of Alma
23 Ata, rightly pointed out that “The conceptualization of “primary health care” was
24 based on erroneous and biased perceptions of the experiences of Third World
25 countries in providing health care with limited resources. In particular, the Chinese
26 experience with “barefoot doctors” was interpreted simplistically and superficially.
27 (Tejada de Rivero). In this paper I have shown that the Barefoot Doctor programme
28 was born out of specific political and economic context of the Maoist period. While it
29 did for a short period of time between 1965 and 1978 provide invaluable healthcare
30 and aid to millions of villagers in the countryside, it was poorly conceived with a
31 short-term goal to provide the simplest and least expensive healthcare. Since the
32 collective socialist economic system or the planned economy was fundamentally
33 flawed, decentralization of healthcare within this system was not sustainable. Once
34 the farming collectives or the People’s Commune were dissolved after the death of
35 Mao, and the household responsibility system (包产到户) was introduced, the
36 cooperative medical service, which provided the framework for the Barefoot Doctors
37 programme no longer was economically viable and collapsed. According to a former
38 barefoot doctor, “After the introduction of the household responsibility system, there
39 was no more work point system, so I could not earn a living as a barefoot doctor. As
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56 ⁴² Zhou, Xun “From China’s Barefoot Doctor programme to Alma Ata”, conference paper delivered at
57 IHOs: The History for the Future Network international Conference, April 2015.

58 ⁴³ Zhou, Xun “From China’s Barefoot Doctor programme to Alma Ata”, conference paper delivered at
59 IHOs: The History for the Future Network international Conference, April 2015.
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1 each family received private plots, all family members were needed to work in the
2 fields. Even if I wanted, I would not have [time and energy] to continue to serve as a
3 barefoot doctor.”⁴⁴ As the private income increased, there was little incentive for
4 individuals to stay on as barefoot doctors.

5 On the other hand, in my most recent fieldwork trip to a village in Zhejiang
6 province, I learnt that after the government’s abandonment, the local villagers opted
7 to keep the co-operative medical service. The village had a small hardware factory. It
8 made a good profit. So the villagers decided to use the money to set up a village
9 health fund to be used by those villagers in need. “This had nothing to do with the
10 government policy. It’s what villagers wanted.” a local villager tells me.⁴⁵This
11 example as well as the other examples I have given in this paper suggest that to a
12 great extent it was the local agency and the shared aspirations to make things better
13 amongst people themselves contributed the success of public health in PRC.
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15 Furthermore, as we have also seen, the outcome of the programme depended more
16 on the policy implementation than the formulation. The activities of the barefoot
17 doctors and local cadres on the ground affected the actual healthcare delivery. This
18 however has its limits. In times of scarcity, favoritism and discretion became
19 unavoidable. This would lead to inequality within communities with fellow villagers
20 competing for resources.
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22 The other issue we can learn from the Barefoot Doctor experience as discussed
23 here is the importance of local worlds and the values embedded in them in healthcare
24 provision. Healthcare should be more than clinic care or giving out pills. Trust and
25 respect between those who deliver care and those who receive care is equally
26 important in healthcare delivery and generating wellbeing.
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⁴⁴ “The Female Barefoot Doctor from the Shore of Dian Lake” in *From Barefoot Doctors to Village Doctors*.

⁴⁵ Interviews with villager X (anonymous) at Fuyang County in Zhejiang Province, April 28, 2015.

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