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Original Paper

Solve the Plight of Rural Healthcare Talent from the Success of the Barefoot Doctor Period

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Abstract

The Barefoot Doctors (BDs) have contributed tremendous strength to the protection and promotion of the health and well-being of vast farmers in China, and the country's three-tiered medical and preventive healthcare network of counties, townships, and villages is widely acknowledged as a valuable experience in providing rural healthcare in developing nations. In the twenty-first century, China's rural health care is facing new opportunities and challenges in terms of talent issues. In order to provide a new avenue for the survival and advancement of rural health care workers in the twenty-first century, this paper addresses the predicament of the current workforce and incorporates an interview with Ms. Song, a former barefoot doctor, to distill the successful experience and propose a solution to the current predicament.

Keywords

rural medical, rural healthcare professionals, barefoot doctors

1. Introduction

The "Developing and Strengthening the Rural Medical and Healthcare Talent Team" guideline is presented in *The Opinions on Further Deepening Reform and Promoting the Healthy Development of Rural Medical and Healthcare System of 2023*. Its objectives are to enhance the health of rural residents and to support the sustainable growth of rural medical and healthcare endeavors. Enhancing the healthcare and medical infrastructure in rural areas is crucial for advancing the development of a healthy China, and it is also the correct definition of advancing the revitalization of the countryside. (The Opinions on Further Deepening the Reform and Promoting the Healthy Development of Rural Medical and Healthcare System issued by the State Council of the People's Republic of China, Developing and Strengthening Rural Medical and Healthcare Talent Team, 2023) The medical professional team also plays a crucial role in the

development of the rural medical and health system. The state has invested significant material resources and introduced a number of public policies since 2000, under the direction of the government health system, with the goal of providing health talent to rural areas. However, the paradox of the "surplus-scarcity" of medical personnel in urban and rural areas remains unresolved, and the shortage of medical personnel in rural areas remains a problem. The paradox of "surplus and shortage" of medical personnel in urban and rural areas lies in the path of progress in rural health care.

Chairman Mao Zedong's directive to "put the focus of medical and health care work in the countryside" in the 1960s and 1970s led to the emergence and quick growth of barefoot doctors and the brigade co-operative medical stations they oversaw in the vast rural areas. A group of medical and health professionals who could treat common and frequent diseases in rural areas, who were ingrained in the rural soil at the grassroots level, and who the rural economy could afford to support and retain. (Wen, 2005) Made a significant contribution to the promotion and protection of the lives and health of a large number of rural people, and at the time created the "World Health Miracle" under China's economic circumstances. At that point, this led to a "global health miracle" and left behind for China experience in rural health work that is worth exploring.

Medical and health care personnel serve as the gatekeepers of rural residents' health at the bottom of the medical and health service network. This paper intends to using Ms. Song, a barefoot doctor in Heilongjiang Province, as a case study, the comprehensive use of literature and oral history, once again look back at the then social context of the barefoot doctor's work and life in the specific scenes. Through the experience of rural medical and health personnel in the period of barefoot doctors, efforts have been made to solve the problem of talents in the rural grassroots medical and health care undertakings.

2. Dilemmas Faced by Rural Healthcare Professionals

2.1 Shortage of Health Personnel Makes It Difficult to Cover the Last Kilometer

According to the *2023 China Statistical Yearbook*, the number of village doctors has declined sharply in recent years, and as many as nearly 30 percent of them are over the age of 60. As of 2022, the number of rural doctors and health workers in China was 665,000, while the number of village health rooms in China was 58,000, and the phenomenon of village health rooms being idle or village doctors being affiliated with these facilities is not uncommon. The following information about the educational backgrounds of health technicians in primary healthcare facilities in 2021 is taken from *The 2022 China Health and Wellness Statistical Yearbook*: (National Health and Wellness Commission, 2022) The proportion of postgraduates, undergraduates, and specialists in township health *cente*rs is 0.1%, 23.9%, and 43.3%, respectively, and that of urban community health centers is 1.9%,42.1%,and 38.1%,with the

educational level of health technicians is significantly lower than that of urban areas, and the level of medical services is relatively backward.

To enumerate the plight of the rural health talent shortage in three main areas:

1) Fault lines in rural health talent: the structure of talent in the health sector should ideally consist of three generations-old, middle-aged and young—to form an echelon. However, at the moment, the proportion of young village doctors in China's wide rural areas is extremely small.

2) Loss of rural health talent: Within the framework of the urban-rural dual structure, health talent flows in both directions: from lower-level health organizations to higher-level health organizations, and from rural to urban areas. This clearly unidirectional flow of health talent results in the village health office, (Tian, 2019) which is at the bottom of the hierarchy, having no room for risk transfer. Additionally, after the rural doctors are poached or leave to pursue better opportunities, many clinics have been forced to close, which has led to a blank village situation.

3) The supply-side structure of medical education: on the one hand, colleges and universities recruit medical students for targeted training in the relatively backward rural areas of the region, but they face the problem of many graduates defaulting on their contracts; on the other hand, graduates from vocational education face problems with their qualifications and social treatment, which has led to the phenomenon that China's medical education has been facing the problem of "planting broadly but not harvesting thinly".

2.2 Poor Functioning of Staffing Mechanisms Due to Irrational Talent Policies and Management Models

With the reform and opening up, and rise of the "engagement economy", the income level of rural doctors practicing medicine in villages has relatively declined, and they no longer have the superiority of intellectuals jumping out of the farm gate in terms of their personal status; the market mechanism makes it possible to reshuffle the resources of the rural labor force, including rural doctors. There have been two major issues with rural medical and health care staff in recent years. One is that issues related to talent policy, insurance coverage, and doctor pay in rural areas cannot be implemented. From the standpoint of a logical economist, this makes it simple to argue against the problems' interests. One kind is insurance fraud through false patients, false conditions, false invoices and other false behaviors; (Wang, 2021) the second kind is the adulteration of unreasonable content in the diagnosis and treatment process, such as prescribing over-scope examination items, excessive and repeated diagnosis and treatment, and tied selling auxiliary medicines that are not necessary to be used; and the third category is the violation of the medical staff's right to accept or ask for red packets. (Li, 2016) Secondly, the services of village doctors as well as village health offices are purchased by the state, usually placed outside the system of the New Rural Cooperative, and cannot be included in the reimbursement, villagers are not willing to come to the village clinic to see a doctor, the medical personnel at the

bottom of the net loses the significance of their existence, and the wastage of the personnel team is intensified. (Sun, Wang, X. Y., Wang, C. et al., 2011)

Although the government has made substantial financial investments in rural health-care institutions, it has played the role of a bottom-up guarantee. However, with regard to talent, it has been difficult to implement a system of incentives for rural medical and health care personnel in terms of salary and benefits, and it has been difficult for county and township governments to get money for differentials. In the face of the plight of the brain drain, only in the administrative establishment, treatment, try to retain retirees, and the newly added village doctors' social insurance and medical insurance have not been applied for a long time, can only wait for the empty space to fill, so that the entire talent system cannot come in, cannot come out, resulting in a "bloated-shortage" of the talent dilemma. The New Rural Cooperative medical system mainly focuses on the reimbursement of major illnesses, and minor illnesses such as headaches and cerebral fevers that are common in daily life are not included in the scope of reimbursement, which makes many farmers not go to the village health clinic to see a doctor, and the operation of the health clinic naturally deteriorates, and the grass-roots health care personnel who are unable to make ends meet are forced to lose their jobs.

2.3 The Lack of a Practical Match between Training Methods and the Culture of Society Has Led to the Saying "Position and Morality Cannot Coexist"

Since the 1980s, barefoot doctors have been renamed rural doctors, and they are required to pass a Physician Practice Examination in order to be qualified to practice medicine. This is undoubtedly a major initiative to improve the quality of medical services for rural doctors, but there are also many practical problems with its implementation. Jin According to Jin Jianqiang scholars, one of the main causes of the dearth of rural medical practitioners in China is that the country's current physician qualification examination application requirements (education, age, and difficulty level) are disconnected from the realities of rural areas. (Jin, 2009) Chen Tao scholars also highlighted the following: there is no targeted setting of the examination and access standards; the content and standards of China's medical licensing examination are nationally uniform, according to the score from high to low for admission, and for the phenomenon of different practical situations between regions, there is no targeted setting of the examination and access standards. Due to the generally lower academic qualifications of grassroots medical students, the examination pass rate of primary care physicians is lower, which is the main reason for the decrease in the number of primary care physicians. (Chen, 2016) Considering the current state of affairs in rural China, general practitioners—or those better suited to the country's rural terrain—and China's current practitioner subjects are divided into four categories of practitioners: clinical, public health, stomatology, and traditional Chinese medicine practitioners, even if they have obtained the qualification certificate, their consultations are often subject to the constraints of not being able to conduct cross-disciplinary

consultations.

In traditional Chinese culture, the concept of identity hierarchy is rooted in people's hearts, and with the establishment of medical institutions corresponding to the level of administrative division, (Yang, 2023) some rural doctors face a subconscious identity awareness barrier when it comes to treating identity recognition disorder. With the arrival of the new era, the life and spiritual level of farmers have been improved, coupled with some existing health insurance and medicine financial chaos, they are more inclined to go to the county-level hospitals and above to seek medical services. Worship and trust for rural health offices and doctors have also greatly reduced, which is a significant departure from the extremely harmonious doctor-patient relationship in the time of the barefoot doctors. This has led to an obvious gap between rural doctors in terms of social and cultural factors, which not only affects their motivation and professional identity, but also restricts the development of rural medical and health care personnel.

3. Strategies for Solving the Dilemma of Rural Medical and Health Care Personnel from the Successful Experience of the Barefoot Doctor Period

In the 1970s, with the widespread implementation of the rural cooperative medical service throughout the country, the barefoot doctors' group became the focus of much attention and won wide recognition and praise from society. The medical model of this period, despite the simple equipment and the fact that the system was still in the exploratory stage, but effectively solved the problem of the shortage of medical resources in rural areas through primary medical care and human services. The Barefoot Doctors contributed to the prevention and control of diseases in rural areas by popularizing health knowledge and improving the health literacy of farmers through regular patrol medical service and health education, as well as the innovations in doctor-patient relationships, training methods, and management models demonstrated during this period. These insights and experiences have a significant impact on how modern rural medical and healthcare professionals grow. By learning from the practical experience of the barefoot doctor period and combining it with the development of modern medical science and institutional policies, we will continue to improve the system of rural health care personnel and provide more scientific and efficient medical services for the rural masses.

3.1 Reclaiming the Intimacy and Trust of the Patient Relationship of the Barefoot Doctor Era

Barefoot doctors were called "the peasants' own doctors", and the peasants gave them political trust and cultural respect. The candidates for barefoot doctors training at the time had to meet two strict requirements: they had to be politically and ideologically sound, come from a good family background, and prioritize the children of lower-middle-class and impoverished parents who met the above criteria", (The Party Committee of the Ministry of Health., 1965) as well as those who have a degree of primary, junior and senior high school education. The rural people,

especially the poor and lower-middle peasants, had a deep trust in the barefoot doctors, a trust that stemmed from the historical background of the countryside and the political consciousness cultivated through years of propaganda and education. Additionally, the barefoot doctors' writings were widely publicized by the press, radio, and cinema, and the term "barefoot doctor" seemed to have originated from a noble vocabulary that reverberated across the great river north and south.

The majority of barefoot doctors have genuinely embodied the medical profession's "treating patients like family members" credo. Most of them were selected and trained by local villagers and returned to the local villages, and their relationship with the villagers was either with their own families, neighbors or classmates, etc. Through a complex and deep network of human interactions, the contact between the doctors and the patients amounted to much more than just a patient-doctor relationship. The ideological education received by the barefoot doctors—to serve the people wholeheartedly, to carry forward the humanitarian spirit of the revolution, and so on—reinforces the fact that the vernacular society "sustains private morality" (Wang, 2011). The winds of politics may blow over sooner or later, but the link of hometown camaraderie will always blow.

Ms. Song, who worked as a barefoot doctor, recalls:

Whenever I visited people's homes, everyone was very welcoming and respected me. I had to eat at my folks 'house when I was assisted-delivery. There was no white flour at home, so they went to other people's houses and borrowed flour to cook for me. I used to tell them that since I was a doctor and had a duty to take care of you, I could eat anything and they shouldn't worry about me. The villages within the brigade were quite far from one another, and despite their own financial hardships, the locals would drive their oxcarts to fetch me when they asked me to visit them for medical attention.

Even though they were so poor in those days, when I gave birth to my child, they sent more than 3,000 eggs and four or five bags of flour to my home. On the day I moved from the village to the city, the family of a woman who had given birth came to me, and I left the moving truck and ran after them. To be honest, I would no longer be a barefoot doctor if I left the community. However, I reasoned that it was my obligation as a doctor to use my medical ethics to solve the problems of the patients in my brigade, I have to stand on the last post well.

The day the moving truck left, everyone was crying. Even after so many years, every time I went back to the village, everyone still came to see me, and the relationship with the villagers at that time was really good; I genuinely missed them. Doctors, we have to have a human interest, I have to prescribe at least thirty or forty prescriptions a day, hard I do not feel hard, I feel very honorable, as long as my patients are good, I will be at ease.

China's rural barefoot doctors use the most simple way to let the "humanistic care" advocated by modern medicine shine on the Chinese countryside. (Liu, 2021) In order to create a culture of

respect for the practice of rural medicine in social circles, the government should make the public aware of the wonderful deeds and contributions made by rural doctors through a variety of channels and media. This will help the public recognize the resilience and protection of rural doctors as the wind and rain that they are. According to the medical service situation of each place, the software and hardware level of rural health centers will be improved systematically, so as to make the working environment of rural doctors more convenient and comfortable. In the process of hiring rural doctors, evaluating their titles, and addressing other issues, raising their social standing through promotion channels would help the villagers recognize and value them more and actively cultivate a positive doctor-patient connection. Rural doctors themselves should always be patient-centered, caring for the plight and needs of the majority of patients, and providing more accurate and effective medical services for patients, thus enhancing the reputation of rural doctors and service evaluation.

3.2 Taking a Leaf out of the Barefoot Doctors Period of Training

In the 1960s and 1970s, China established three major health systems in rural areas, consisting of the "barefoot doctor", "the rural cooperative medical system", and "the three-tiered health care network". This system was once recognized internationally as China's main approach to "obtaining the greatest health benefits with the least investment". (Hu, 2008) Barefoot physicians are first chosen in the community, then after receiving approval and assignment from the village or local government, they attend the county health school for one to three years, or even longer, to complete their training. After that, they return to the villages to resume their work. In order to improve the medical level and service capacity of barefoot doctors, China has carried out various forms of on-the-job training. Centralized training in county hospitals or community health centers is the most popular type of instruction. In addition, regular meetings for business study, correspondence courses, formal training at health schools, and training for medical teams in the countryside are also important forms of training. In accordance with instructions from the Central Government, medical staff from big city hospitals and the People's Liberation Army also dispatch a number of capable traveling medical teams to train barefoot doctors.

"Barefoot doctors" are generally able to master the diagnosis and prevention of 100–200 common and frequent diseases in rural areas, apply 100–200 Chinese and Western medicines, use acupuncture and moxibustion at more than 100 acupuncture points, and administer everything from Chinese herbs to Western antibiotics, and even simple surgical procedures. The application of the new midwifery method in gynecology and pediatrics has resulted in a notable decrease in the overall death rate of expectant mothers and babies. (Zhang, Wen, & Liang, 2002) Under the guidelines of the "Three Earths and Four Selves", barefoot doctors and peasants have actively explored and used Chinese herbs to treat illnesses with herbs and earth prescriptions. As consequently, the culture of traditional Chinese medicine has grown in an unparalleled manner.

Ms. Song recounted:

We must select clever individuals with junior and senior high school education from the community, taking into account the family structure in addition to your ability to manage your affairs. Following the selection of our group's unified organization in the county-wide learning classes at the hospital, we learned how to inject first, followed by vaccination, acupuncture, gynecology, pediatrics, and so on. Regardless of whether Chinese medicine and Western medicine should be learned, everyone should become a unique and comprehensive hand, everyone would cure the disease. Our teachers included graduates of the Harbin Medical University, veteran Chinese medicine practitioners who had been seeing patients for decades, and full-time obstetricians and gynecologists. Over the course of my three years as a general practitioner student in the county, we followed the teacher to the countryside to see patients, participate conducting camp and field training, and learnt a lot of knowledge that can be directly used in practice. I was responsible for patients with conditions such as midwifery, vaccinations, colds, pneumonia, tuberculosis, heart disease, sepsis, neonatal conditions, gynecology and pediatrics, and so on. There is a kind of scleroderma neonatorum, theoretically the mortality rate is 98 percent, but for the children who have passed through my hands, I use acupuncture, Chinese herbal medicine, and a set of prescription, none of the children died.

Today's medical personnel training model can take the "barefoot doctor period" as a model, and endeavor to strengthen the cultivation of rural general practitioners and improve the overall quality and level of the current rural grass-roots medical and healthcare team. We will continue to enhance the policy mechanism for the cultivation of rural-oriented medical students in the areas of top-level design, talent cultivation, curriculum construction, clinical practice, etc. By utilizing the Ministry of Education's opportunity to promote the implementation of the excellent doctor education and training program, combining the actual needs of rural medical and health services, and collaborating with the local government, local colleges, and universities. (Xu, 2023) Taking positions as the leading role, cultivate oriented talents close to the position needs of rural doctors. Establish medical ethics and a medical style, study with Chinese medicine practitioners, teach by example in the clinic, incorporate Chinese medicine instruction into the training program, and develop Chinese medicine talent that is tailored to the requirements of rural medical and health services. The difficulty and content of the license exam should be tailored to the real circumstances of providing medical care in rural areas, and the practice itself should be localized, practical, and standardized. Really cultivate a group of "can-pick-up, top-of-the live" rural doctors.

3.3 Improve the Management Model and Draw on the Cooperative Medical Management Strategy

The cooperative medical management model from the 1970s was influential in the field of rural health, and it is still worthwhile to research the communal brigades' administration of the

barefoot doctors. At that time, farmers only needed to pay a small amount of money annually or could even use Chinese herbs or grains in place of the fund-raising money. (Peng, Lv, Wang et al., 2011) The funds for cooperative medical care came primarily from individual fund-raising and the brigade's allocation. The majority of the villagers' medical costs were covered by the cooperative medical care, and the money was utilized to open pharmacies and purchase medical supplies. The majority of rural residents were drawn to the convenient and reasonably priced policy. Once they realized the advantages of receiving medical care, they became even more eager to cooperate, which eventually provided barefoot doctors and cooperative medical care with a large mass following.

The value of the barefoot doctor's labor and the remuneration for his labor were realized through the work points kept by the brigade, such a way of remuneration cut off the interest relationship between the doctor and the patient, and because of the guidance of the political ideology at that time, the barefoot doctor did not have the idea and motivation of overmedicating. On the premise of no interest dispute, the role of the interpersonal relationship model of Chinese vernacular society could be fully manifested, and other factors could also play a role (Wang, 2011).

At that time, the management system of barefoot doctors was also relatively perfect, with brigades directly managing barefoot doctors and assessing their participation in production and labor and their overall performance in the practice of medicine; communes restraining them administratively; commune health hospitals guiding and training barefoot doctors and providing them with regular business assessment and guidance; and the county health bureaus managing them indirectly. The collective economy guaranteed the regular operation of the brigade health office, and in the context of the three-level network of prevention and healthcare at the time, the county, commune, and brigade were all in charge of managing the village clinics and the work of the barefoot doctors. So under such a management system, the profit and loss of the operation of the village clinic were not a matter of excessive consideration for the barefoot doctors, who were more capable of devoting themselves to the provision of health care services for the townspeople. (Sun, Wang, X. Y., Wang, C. et al., 2011)

In this regard, Ms. Song said:

In my opinion, the farmers greatly benefited from the communal medical care. To ensure that everyone could afford to take the medications, farmers contributed a small amount collectively, and the brigade would be compensated for the cost of the medications as well as the expense of traveling to the county hospital for medical attention. We went to the doctor to get the delivery fee, which we then turned in to the brigade. The money was then utilized to buy medication that the people may need. Our pay was based on the quantity of work points we were given, and all fees had nothing to do with our salary; instead, they were measured in centimeters. At that stage, we also assessed the brigade's advanced members based on the number of centimeters they had received. The number of centimeters we had received was determined by our work output,

attitude toward serving others, and technical proficiency; if the villagers were dissatisfied with our work, we could not have received the centimeters at random. At that time, we followed Mao Zedong's thought, leaders and the peasants should be treated the same way, using medication when they were sick and treating them however they needed to be treated. No one had so much to think about, we were just dedicated to serving the people.

The happiness index of the peasant masses is directly correlated with the quality of care provided by rural doctors, who serve as the major medical services spokesperson and coordinator. (Wang, Tang, Wu et al., 2021) Priority one when building a rural medical talent team is to always uphold the progress and integrity of medical professionals. To ensure that the health care industry and medical and health institutions can be effectively implemented and put into practice, the county health talent policy must be put into practice. This includes the introduction of a perfect mechanism for the introduction and application of the policy, supporting the corresponding policy support.

Second, governments at all levels should fully grant medical and health institutions, as well as the medical community, the authority to recruit, introduce, and cultivate incentives for talent. Additionally, wages and benefits for rural medical workers should be appropriately raised to enable them to fully develop their talents in the vast rural land. Last but not least, talent incentives should be implemented, a sound incentive mechanism that respects the value of talent and the laws of growth should be established, and the urban-rural mobility of medical talent should be strengthened.

Third, a new structure of fair allocation at the county, township, and village levels should be formed, and the active development and expansion of the talent team at the county level of administration should be encouraged. Furthermore, the assessment and supervision should be put into place to strengthen the annual assessment of the construction of county-level health personnel and to support integrated management of county medical and health care personnel.

Fourthly, it's important to cultivate ideological awareness. The primary duty of the health care authorities' party style and clean government construction should be consolidated under the direction of party building. Strengthening the party style, clean government construction, and disciplinary control of healthcare facilities are necessary. (Yang, Ji, & Huang, 2021) In terms of philosophy, establish cutting-edge conventional models, garner media attention and recognition, and actively push the development of a hygienic medical facility with high standards for medical ethics and a hygienic culture.

4. Concluding Remarks

The research presented here examines the difficulties faced by rural medical and healthcare workers in detail, this paper looks back at the successful experience of the barefoot doctor era and draws wisdom from it to solve the current predicament. Although the medical facilities of

that era were rudimentary and the medical model was plagued with all kinds of problems, but the Barefoot Doctors' team embodied the human touch and professionalism that are lacking in today's rural medical care. The state has undoubtedly expended a great deal of time and money reforming rural healthcare over the years, but the problem of rural healthcare talent will not be resolved overnight. We must accept the situation as it is, rise to the occasion, and progressively address the lack of qualified medical and healthcare professionals in rural areas through monetary assistance, model innovation, leadership development, and policy direction, among other means. To investigate a rural medical development route with Chinese characteristics in the ongoing practice and summary.

"With medicine boxes on their shoulders, mud under their feet, and the people in their hearts", the group of barefoot doctors who trekked on mountain trails in worn-out shoes have gone far away with the development of the times, and the rural medical talents who use their hands and knowledge to deliver health and happiness to the people in rural China in the new era are still struggling on the front line. It is envisaged that with the combined efforts of the government, society, and individuals, the hardship of rural medical and healthcare talents can be effectively relieved, and that rural medical and healthcare endeavors would deliver increasing advantages to the Chinese people.

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Appendix:

synopsis of an interview

1. When did you take up the job?
2. What are the criteria for selection for training as barefoot doctors?
3. How were barefoot doctors trained at that time?

4. What medical knowledge was learnt during the training?

5. What else will you do during the training besides learning about medicine?

6. Who were the teachers who trained you at that time?

7. What are the common ailments in the practice of medicine and how are they treated?

8. How is the relationship with patients in the village

9. What financial assistance is received and where does the remuneration come from. What is the funding for medical care and how is it remunerated?

10.Is there any corresponding organization to manage and discipline the barefoot doctors?