Articles

Medical Selection and the Debate over Mass Immigration in the New State of Israel (1948-1951)¹

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Abstract. This paper examines the discourse regarding medical selection of immigrants to Israel during the years 1948-51, which was a period of mass immigration in which approximately 700,000 people immigrated to the State, thereby doubling the Jewish population in only three years. The paper focuses on the debate that preceded the Israeli Government’s eventual acceptance of a selection policy. We assert that the debate was shaped to a large extent by a combination of Zionist ideology and eugenic influences—two intellectual forces that had interacted well before the creation of the Israeli State in the first half of the 20th century.

Résumé. Ce texte porte sur le discours relatif à la sélection des immigrants en Israël durant les années 1948-51, période durant laquelle environ 700,000 personnes émigrèrent dans ce pays, ce qui fit pratiquement doubler la population juive en trois ans. Il traite plus particulièrement du débat concernant les politiques de sélection pratiquées par le gouvernement israélien. Il ressort que ce débat fut influencé, pour une grande part, par la rencontre de deux courants de pensée, soit les idéologies sionistes et les idéologies eugénistes; deux ensembles de doctrines bien vivantes dans la première moitié du XXe siècle.

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INTRODUCTION

The marking of the immigrant as an Other by veteran populations—a recurrent theme in various societies and time periods—is commonly achieved through images of health and illness, with the immigrant seen as a source of disease, crime and social ills that “pollute” local society. The tie between immigrant and health raises issues of prejudice, racial discrimination, and equality in access to health services. In recent years questions of health and immigration have been fueled by “globalization” processes; as migration occurs with greater expediency and ease, the ties between health and immigration become increasingly salient. The bearing and form that these issues take on do, of course, vary according to the context of time and place. Indeed, as this paper aims to illustrate, the State of Israel constitutes a unique test case for issues of immigration and health.

The process of Jewish immigration to Israel in the 20th century is a topic enveloped by debates over how that immigration should have proceeded. On the one hand, consonant with the basic tenets of Zionism is the belief in entirely unrestricted entrance for all Jews; on the other hand are those arguments for selectivity based on various guidelines, including medical criteria. Although the Zionist Jewish Agency had already enacted a medical selection policy in the 1920s, it was only after the establishment of the Israeli State in 1948 and the mass immigration that followed that the issue of medical selection became a subject of intense debate amongst physicians and politicians. This debate would cast a shadow of suspicion on all who contributed to the development of immigration and absorption endeavours. Most significantly critics have charged those proponents of medical restrictions to immigration with practising ethnic discrimination.2

The subject of this paper is the debate surrounding medical selection. Our focus on the years 1948-51 is based on two main points. First, these years are defined in Israeli historiography as the years of mass immigration to Israel in which, over a short period of time, about 700,000 people immigrated to the State. In 1952-53 there was a sharp decline in immigrant numbers, thus defining the boundaries of a period. Secondly, in 1951 the Israeli State officially declared its medical selection rules for screening immigrants. This paper discusses the debate over medical selection which preceded the acceptance of the selection rules by the Israeli government. It is our claim that the debate was shaped to a large extent by the combining of Zionist ideology and eugenic influences—two intellectual forces that had interacted with each other well before the creation of the Israeli State in the first half of the 20th century.3 Despite the broad support that the medical selection policy enjoyed amongst the medical profession and the political establishment in Israel, its imple-
mentation during the period of mass immigration in 1948-51 was limited, mainly due to practical and humanitarian reasons. Its application on a broad basis after 1951 was against the backdrop of a dramatic change in the demographic composition of the immigrant population, which then was arriving in large numbers from North Africa and other Arab countries. Gradually the medical policy was taken over by a selection that was based more on social criteria, i.e., age and the family as a selected unit.

HEALTH AND IMMIGRATION

Over history, as methods of transportation increased and improved, easing the transfer of goods and people between countries, various laws developed in order to prevent the spread of epidemics. As early as the Renaissance, quarantine served as a key method used in the hands of the authorities and public health officials for preventing the entry of ships, cargoes, and passengers feared to be carriers of disease. The quarantine did not focus on the individual; rather it was applied to the entire ship, the entire cargo or all the passengers. With the rise of bacteriology in the closing third of the 19th century, various countries initiated examination and selection practices for immigrants on an individual basis. For instance, in America between 1 January 1892 and 19 November 1954, 12 million immigrants underwent medical examinations designed to establish whether they were suited to enter the United States. In order to appreciate the key role medical personnel played in immigration, one should keep in mind that medical criteria were amongst the most important conditions for immigrants’ acceptance to the United States and Canada at the outset of the 20th century.

The role of medicine and public health personnel in classification and absorption of immigrants in many countries at the turn of the 20th century went beyond scientific facets. Various studies of health and immigration, particularly in regard to the United States and Canada, reveal a close linkage between medicine, society, and culture in absorption of immigrants. Xenophobia among veteran populations was expressed in public health officials’ policies as well. One encounters many restrictions to immigration based on “objective” or “scientific” grounds that viewed immigration as a public health threat. Indeed, prejudices towards various ethnic groups underwent “medicalization” in the course of the 20th century—a trend reinforced by the rise of bacteriology and the possibility of carrying out laboratory tests that would identify sources of disease. It is not the intention of the authors to mitigate the importance of medical examinations or to claim that immigration does not carry important health challenges. However, a large number of historical works indicate how thin the line can be between scientific and objective criteria and unfounded prejudices and racism. Often metaphors associ-
ated with disease, disease-producing germs, and their carriers were asso-
ciated with immigrants indiscriminately, “marking” entire populations
without any justification.9

Beyond nativism and the rise of bacteriology, eugenics had a core
impact on the formulation of immigration policy in the first half of the
20th century. As already noted in numerous works, eugenics was a major
force within the social and political discourse.10 The rise of public health
combined with the new scientific methodologies of bacteriology and
eugenics exerted a decisive influence on immigrant absorption issues.
Even those who favoured absorption of immigrants regarded educa-
tion and assimilation within the absorbing society to be imperative.

It would appear that in Israel these factors also had an impact on the
absorption of mass immigration during the first years of the state. The
huge influx of Jews from various communities in the Diaspora brought
immigrants with a high incidence of disease, placing a heavy burden
on the Israeli health system which was struggling under the constraints
of meager budgets and an inadequate number of personnel. Tuberculo-
sis, trachoma, syphilis, and other contagious diseases whose incidence
had been reduced in Mandate Palestine in the two decades preceding
the establishment of the state, genuinely threatened to break out anew,
and fear of such an event was expressed in the attitudes and policies
adopted by health system personnel at the time.

Even those leaders of the young nation, including David Ben-Gurion,
who fervently believed in the principle of open immigration, ultimately
had to acknowledge the overriding need to protect public health. Yet it
would be a mistake to dissociate the real desire of the medical estab-
lishment to protect public health from the social and cultural dimen-
sions of immigrant absorption policy during these years. Israeli society at
this time was in the midst of a long process of crystallizing its identity, an
ongoing process that is expressed in health and immigration issues to
this day. The immigrants of that time, who were primarily Holocaust
survivors and immigrants from Arab countries, presented a dual chal-
lenge to veterans who feared both the diseases they might be harbouring
as well as the impact these “problematic populations” might have on
the nation’s identity.

One should not lose sight of the fact that many of the dominant lead-
ers in the Israeli health system at the time were themselves immigrants
who had received their training at medical schools in Central Europe
and the United States, a fact that influenced the core role they assigned
public health. The interface between the desire to protect the health of
the public, the policy-makers’ Zionist ideology and their exposure to
eugenic thought forged a complex outlook for dealing with heteroge-
neous groups of immigrants. Through a discussion of medical selection
one can trace how, in the first years of statehood, the Israeli medical and
political establishments approached the triad of health, immigration, and identity.

IMMIGRATION BEFORE INDEPENDENCE

At its core, Zionism envisioned a Jewish state that would serve as a shelter for any Jew who wished to live there. Nonetheless, even before 1948, the specific needs of the imagined state often demanded selectivity from the Zionist agencies that organized Jewish immigration.

From the establishment of British civil authority in the beginning of the 1920s, British immigration policy stipulated the various categories of Jews who could receive permits to immigrate to Palestine: The first—Category A—was reserved for “capitalists,” whose numbers were not great. The third and main group—Category C—related to labourers, whose numbers hinged on the economic ability of the country to absorb them. This quota, adjusted every six months, was entitled the immigration “schedule.” Another grouping—Category D—covered dependents of the first two categories (such as children and women) whose livelihood depended upon the earning power of inhabitants of the country, or support from abroad. The number of capitalists was not subject to a quota—political or other—and permits were weighed on an individual basis according to the circumstances of the applicant. On the other hand, Mandate authorities permitted the Jewish Agency to control immigration policy among the other two categories. According to the mandate granted the British over Palestine, the Jewish Agency—an arm of the Zionist movement designed to champion and assist Jewish immigration and settlement in Palestine—was entitled to arrange and control the immigration of Jewish laborers—Category C. Control over C category applicants allowed the Jewish Agency to monitor the core component in Jewish immigration. Subsequently, the Jewish Agency adopted a policy that championed immigration of only the Zionist elements who were healthy in body and soul and capable of assisting in the building of a future Jewish State. At the same time the Jewish Agency prevented the immigration of others who did not meet Zionist criteria.

When the British Mandate imposed quotas, it did not implement any selection processes in order to determine which individuals won the prized entrance visas. In order to ensure its own goals, however, the Palestine Zionist Executive instituted a medical certification process. Naturally, young and healthy applicants, who could best enhance the effort to bolster Jewish presence in Israel through settlement, received preferential treatment. The limitations imposed by Mandate authorities, in practice, forced the Palestine Zionist Executive to prioritize applicants.

But the medical selection process took place also after immigrants had arrived. If a young immigrant was discovered to be ill, the Secre-
tariat for Health Matters of the Jewish National Committee in Israel (the body that provided self-governance among Jews in Mandate times) together with the Jewish Agency undertook to return the individual to his country of origin, a step co-ordinated with the returnee’s family. By the close of 1930, the number of immigrants returned to Europe reached several hundreds; the list of maladies cited included mental illness, tuberculosis, heart disease, diabetes, and intestinal diseases. In this manner, the cost of treatment was saved and the immigration certificate passed to an able-bodied young person. It is interesting to note that at least according to our current historical knowledge, no open debate was found regarding the issue of medical selection by the Jewish Agency during the British Mandate.

In the wake of World War II, for political and humanitarian reasons, Zionist agencies eschewed all medical selection. But very soon after, in its first months of existence the Israeli State witnessed the rise of a fierce debate on whether to enforce a medical selection of the huge waves of immigrants entering the young country.

MASS IMMIGRATION TO ISRAEL

Demographic Characteristics

After World War II, European refugees who had survived the Holocaust constituted the main source for mass immigration to Israel. From 1945-48, some 100,000 survivors came to Israel, as well as a group of 50,000 illegal immigrants; all were European. After this, between May 1948—the founding of the new state—and 1951, Israel experienced an influx that more than doubled its population. The first four years of this, from 1948-51, brought in a very diverse and very large group: some 700,000 people, half from Europe and half from Africa and Asia (primarily Yemen, Iraq, Iran, Turkey, Libya, Tunis, and Morocco). Anyone who claimed he was a Jew was received. From 1952-54, after Israel established the Law of Return and adopted official medical selection rules only 35,000 immigrants arrived, most from North Africa. Almost 50% of the 1952-53 immigrants left Israel shortly thereafter (Table 1).

These statistics place the State of Israel in a class of its own as a country in which immigration reached a scope heretofore unprecedented in modern times. Even countries such as the United States and Canada never absorbed as many immigrants in so short a time relative to the size of the absorbing society. Indeed it is interesting to compare Israel’s numbers with those of other “classic” immigration countries during the same period. In the two decades following World War II the US received approximately 250,000 immigrants per year, Canada received 120,000 per year and Australia’s annual number was at 100,000. Thus, the number of immigrants being absorbed in Israel in this period is comparable to the numbers being taken in by other larger immigration countries.
When one adds to this reality the underlying Zionist ideology and the heterogeneous character of the immigrants, the Israeli case stands out as a unique example in the history of immigration.

Table 1

<table>
<thead>
<tr>
<th>Year/Origin</th>
<th>Europe-America</th>
<th>Asia</th>
<th>Africa</th>
<th>Unknown</th>
<th>Total %/people</th>
</tr>
</thead>
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<tr>
<td>1948</td>
<td>75.5</td>
<td>4.5</td>
<td>8.0</td>
<td>12.0</td>
<td>100 101,819</td>
</tr>
<tr>
<td>1949</td>
<td>51.5</td>
<td>30.0</td>
<td>16.5</td>
<td>2.0</td>
<td>100 239,076</td>
</tr>
<tr>
<td>1950</td>
<td>50.0</td>
<td>34.0</td>
<td>15.0</td>
<td>1.0</td>
<td>100 169,405</td>
</tr>
<tr>
<td>1951</td>
<td>29.0</td>
<td>59.0</td>
<td>11.5</td>
<td>0.5</td>
<td>100 173,901</td>
</tr>
<tr>
<td>1952</td>
<td>30.0</td>
<td>28.5</td>
<td>41.5</td>
<td>–</td>
<td>100 23,357</td>
</tr>
<tr>
<td>1953</td>
<td>28.0</td>
<td>27.5</td>
<td>44.0</td>
<td>0.5</td>
<td>100 10,347</td>
</tr>
<tr>
<td>1954</td>
<td>14.0</td>
<td>18.5</td>
<td>67.0</td>
<td>0.5</td>
<td>100 17,471</td>
</tr>
<tr>
<td>Total</td>
<td>343,949</td>
<td>251,279</td>
<td>120,752</td>
<td>19,396</td>
<td>735,376</td>
</tr>
</tbody>
</table>

As one can observe from Table 1, Europeans constituted the primary source of immigration between 1948-50, followed by immigrants from Asia and Africa. There were two prominent subgroups among European immigrants: Romania (35%) and Poland (31%). The majority of Romanian and Polish Jewish immigrants came to Israel between the years 1948-51. Among immigrants from Asia, the most prominent group was from Iraq (50%), while Jews from Yemen and Aden constituted the second largest group (19.5%). The majority of these two ethnic groups also immigrated to Israel between the years 1948-51. The most prominent group among African immigrants was from Morocco, a Jewish community that constituted 56% of all immigration from Africa. The second largest group was from Libya (27%). Most North African Jewish immigrants arrived after 1952. A fact not generally underscored in Zionist historiography is that in the first years of the state, there was not only immigration to Israel. Between 1948-54 the rate of emigration during the same years was 8% of all immigrants. The primary target destinations were Europe and the United States (37% and 41.8% of all émigrés,
respectively.) Among those of European origin, the emigration ratio was 99:1000; among those of Asian origin only 24:10000, and among those of African origin 76.5:1000.

The mass immigration to Israel presented the State with pressing and immediate practical questions. Within a few short years the Jewish population of the State had to absorb hundreds of thousands of immigrants, many of them ill with diseases that required immediate hospitalization. The massive influx of immigrants during the first years of the state strained Israel’s resources, especially since so many postwar immigrant groups were weakened and had higher morbidity rates than those of the veteran population. Arriving in the wake of Israel’s War of Independence, they came without material and financial assets and in varying states of physical and mental exhaustion. Aside from malnutrition, the new arrivals suffered from a high incidence of disease, particularly tuberculosis, ringworm, and trachoma; 10% had medical conditions that required immediate hospitalization. Because the young state had few hospital beds, there was a fear that the sick immigrants would have to go without sufficient care, putting themselves and others in jeopardy.

This grave situation brought to the fore the medical selection dilemma: if and how the immigration should be regulated. The ensuing discussion, informed by the events of the war and the Holocaust, proved difficult from a moral standpoint as never before. The fledgling government had to wrestle with a host of sensitive points. Could they be responsible for postponing immigration of sick Jews—including whole communities—in order to protect the health of the veteran community in Israel? Could they really delay the immigration of Holocaust survivors and compel them to undergo medical examination, ignoring the emotional and psychological impact of such demands on survivors of the concentration camps? To do so would, in essence, turn their previous hardships into a handicap—a secondary form of punishment. Ultimately, the government would have to choose between the Zionist ideal of unfettered Jewish immigration and adapting or compromising that ideal in order to safeguard the survival of the new state.

THE DEBATE OVER IMMIGRATION IN THE NEW STATE

The first official discussion of the issue took place relatively quickly after the establishment of the Israeli State in October 1948, prior to the close of the War of Independence. Talks focused on the state’s ability to direct and control the composition of immigrant groups arriving in the country. The Coordination Institute, which managed immigration and absorption activities in the government, the Jewish Agency, and a variety of other Jewish institutions in Israel and abroad, provided a framework. All the discussants agreed that Israel could not adequately take in and
provide care for new immigrants while waging war, since the state already lacked sufficient resources for its thousands of war casualties. Allowing unfettered immigration would, all agreed, be impossible and irresponsible. Rabbi Moshe Haim Shapira, the Minister of Health in the provisional government, made one of the first explicit arguments for reinstating medical restrictions: “There is another serious matter—choosing the immigrants….Within immigration, there is too high a percentage of elderly and weak who are neither fit for war nor for work….In place of a frail Jew it is possible to bring in a Jew who is able either to work for the economy or wield a weapon…they are taking on to the ships mentally ill and those sick with tuberculosis and all kinds of diseases that are a disaster for the Jewish community and the country.”

Minister of Finance Eliezer Kaplan also came forward in favor of “regulation of immigration in qualitative and quantitative terms.” Aware of the sensitivity of the subject of selection on medical grounds, particularly among Holocaust survivors, Kaplan nonetheless worried that “by lack of any monitoring of immigration, we are creating serious problems in the country.” Arguing further that “in wartime we need immigrants who can be absorbed in the Land of Israel, both in the army and in the economy,” he pointed out that the nation did not have the resources “to open old age homes and facilities for the disabled.”

Despite the consensus among discussants regarding the difficulties of absorbing masses of sick immigrants in Israel, the provisional government failed to reach a decision about restrictions. They left both the moral dilemma and the practical difficulty to the government that would follow them. In January 1949 the nation held elections for its first Knesset—the Israeli parliament—and in March the provisional body gave way to the elected government headed by David Ben-Gurion. The Ben-Gurion coalition brought the dominant socialist Zionist party, Mapai, together with the religious parties; the smaller but militant socialist Zionist party, Mapam, remained outside the government. Rabbi Shapira, who belonged to the United Religious Front party, a forerunner of today’s National Religious Party, continued as Minister of Health. Within a matter of months, this new government had to face the dire circumstances of the poor health of the new immigrants arriving in the country by the hundreds of thousands; at the same time, it had to consider the needs of the populations still waiting in European transit camps.

In April 1949, as the number of ill immigrants arriving in Israel rose, Dr. Yosef Meir, the head of the Kupat Holim (The General Health Fund), the primary health care organization in Israel, called upon the government to immediately postpone the arrival of those carrying contagious diseases or suffering from chronic illnesses. In particular, Meir was concerned about the presence of active tuberculosis, which posed a grave threat to the population at large. It was already clear that tuberculosis
constituted the core health problem of the immigrants, both among Holocaust survivors from the DP camps in Germany and among immigrants from Bulgaria, Romania, and Iraq who were the first large groups to arrive in Israel in 1948. In a letter he sent Shapira, Meir spelled out the urgency of the situation:

According to the evaluation of physicians dealing with tuberculosis, presently there are about a thousand patients with active tuberculosis in the community….One can easily imagine what damage these sick people could bring under the crowding and the hygienic-sanitary conditions prevailing in the [transit] camps….One can [deduce] with [equal] certainty that among the two hundred thousand new immigrants that have come in the past year, there are some 1,700 stricken with active tuberculosis in the Jewish community…without forgetting this number does not include local patients [with tuberculosis] up to this year.  

Meir particularly emphasized the problem of children with tuberculosis, for whom there was not one hospital bed in existing local hospitals. Israel had at the time no suitable solution for tuberculosis patients. In the face of what he perceived to be a potential catastrophe, Meir recommended that Israel keep sick immigrants out for the time being. He pointed out that an offer from American Jews would provide funding for treatment in Colorado and Switzerland. “Instead of bringing ill immigrants here,” Meir argued, “and letting them wander about and infect others due to lack of beds, or to send them from here to America or Switzerland, wouldn’t it be better to take these people straight to countries abroad….and to keep them there until they are cured?”

Meir’s call to put limitations on immigration to Israel after establishment of the state was not a new posture for him. Over the course of many years while serving as a key figure in the public health domain in Palestine, Meir had viewed selection between “sick and well” as an essential motif in preserving the health of the new Zionist nation-in-the-making. As early as the 1920s and 1930s Meir held that Palestine had enough “local disease” and that there was no logic in importing new disease through immigrants. His conclusion was that there was no sense in bringing in sick immigrants who in addition to putting the society at risk would also require expensive care.

As a graduate of Viennese medicine, eugenics was not foreign to Meir and he espoused this approach in publications on public health issues. In an article entitled “Who has the Right to Bear Offspring,” published in the early 1920s, Meir incorporates contemporary eugenic thought: “Doctors, sports personnel and national functionaries need to carry out broad-based propaganda for the idea: Don’t bear children if you can’t ensure they will be healthy in body and soul.”  

In the 1930s, Meir called upon kibbutz settlements to carry out medical tests for applicants seeking to
join the kibbutz and employ selection among them. During the same period, he pronounced “Let not the sick immigrate to the Land of Israel” adding “Our country in its present circumstances needs healthy and strong persons. The weak and the ill fall as a burden on others and on themselves.” Meir was not alone in this outlook and such postures were common to many of his colleagues, who were also graduates of faculties of medicine in Central Europe and brought similar sentiments with them to Israel. While eugenics was placed beyond the pale after World War II, it is logical to assume that Meir’s concerns for public health expressed in his statements on selection during the mass immigration reflect his earlier outlooks and attitudes.31

Although Meir’s arguments in 1949 were central to the debates that took place in the Knesset that spring, tuberculosis was only one part of a much larger picture—a panorama that included the health conditions in Israel, the conditions among the new arrivals, as well as the thousands of aspiring immigrants waiting in the refugee camps in Europe. A detailed record of the situation in Europe came out of the JDC (Joint Distribution Committee), the humanitarian aid organization of the Jewish community of the United States, which took an active part in financing and organizing mass immigration. According to data gathered by Harry Vitalis, the JDC’s representative in Israel, of 120,000 Holocaust survivors who had already been examined in the DP camps before immigrating to Israel, approximately 12,000 needed immediate medical care, including 1,500 with tuberculosis, 400 who were mentally ill, 2,500 who were blind, 3,000 elderly in need of long-term care, and 3,000 unemployed elderly in need of welfare. Three thousand people were disabled and required medical support as well as full or partial long-term care, 600 had other chronic illnesses, and 500 children had mental illnesses, disabilities, or other functional deficiencies.32

In the meantime, the Israeli health system had no long-term medical care solutions available, not even hospitalization. Vitalis estimated the cost of medical care for the 120,000 immigrants who had already arrived, including opening facilities for specialized hospital care and organization for hospitalization of the chronically ill, at roughly 1 million Israeli pounds, the equivalent, then, of 3 million US dollars.33 According to further calculations provided by Dr. Theodore Grushka, Director of Immigrant Medical Services, the total cost for some quarter of a million immigrants projected to arrive by the end of 1950 would come to 2.5 million pounds.34 This expense was, of course, in addition to the medical care the State of Israel would need to allocate for casualties from the War of Independence and care required by the civilian population in Israel.35

As the JDC figures illustrate, immigration presented the receiving nation with a multitude of chores necessary for the absorption and care of new arrivals. Agencies in charge of Israel’s medical services had to
address the needs of the mental and physical well being of the immigrants, which were substantial. Along with social services, these bodies supplied essential medical services in order to safeguard the lives of the newcomers and to protect the public from potential epidemics. The Jewish Agency—which cared for immigrants during their first year in the country—recorded that among the 50,910 immigrants housed in 33 transit camps during the first half of 1949, 1,253 social welfare cases were registered, including 829 ill and disabled, 188 elderly, and 236 widows with children. Because the country’s limited resources were stretched so thin, tenuous conditions prevailed in the crowded camps—including tents without minimal sanitary provisions—and posed imminent health hazards. The infant mortality rate within the camps far exceeded that of the general population: 157.8 deaths per thousand births to 16.2 deaths per thousand births, outside the camps.

The information presented by Vitalis and Grushka, and Meir’s demand for suspended entrance in light of the tuberculosis threat, placed the new government squarely on the horns of a tough moral and ideological dilemma. Officially, at this time, the government maintained a policy of open immigration for all Jews. David Ben-Gurion’s public stance and the decision of the first coalition government endorsed all measures to encourage unrestricted mass immigration in order to double the population of the State of Israel.

As one of the architects of the idea of large-scale mass immigration, Ben-Gurion kept his concerns to himself while calling for open and unfettered immigration as well as demanding that the state adjust itself to meet absorption needs. Nonetheless, Ben-Gurion did not oppose internal deliberations in the government and Knesset on the subject of medical selection.

Ben-Gurion’s worries did not revolve around a specific disease or even the poor health status of immigrants per se; what he found particularly worrisome was the overall picture, which showed that approximately 10% of the immigrants arriving needed medical care. It would place a heavy economic load on a nation still at war for its independence. Ben-Gurion recognized that Israel’s resources were not sufficient to be able to deal with large numbers of immigrants in need of support for employment, education, and housing, let alone healthcare. In his diary during the years 1948-51, he recorded his belief that exceptions to the open door policy should exist: “Among the immigrants there are many sick with tuberculosis and venereal diseases,” he wrote, “and this should be forestalled. In January 1,500 patients with trachoma arrived; these can be cured. Severe disease should be forestalled.” He also remarked there that Israel faced “an immigration...different not only quantitatively but also qualitatively from previous [waves of] immigration.” Since the new arrivals would “come primarily from Jewish centers impover-
ished materially and in spirit,” he worried that “the character of the Jewish community of Israel is liable to be impaired and its pioneering image fade.” He held a particular concern about refugees from the Holocaust, on occasion expressing his fear that the trauma had reduced them to “human dust” and that they no longer had the capacity to become normal citizens. Only four years after the end of the war, in fact, no one knew how Holocaust survivors would readapt to normal life.

Despite his reservations about bringing over sick persons, Ben-Gurion did not issue a wholesale order to prevent their arrival and generally brought all demands to limit immigration for medical reasons to the government or transferred them to Coordination Institute head Yitzchak Rafael, who accepted responsibility for dealing with the issue.

Like Ben-Gurion, JDC officials found themselves torn between principle and practical limitations. Publicly, the JDC maintained that all immigrants should receive equal support and access, with no discrimination whatsoever between the healthy and sick or between the young and old. In discussions between Joe Schwartz, the head of the JDC’s European branch, and the Israeli government, the parties agreed on this policy. Nonetheless, Harry Vitalis, the JDC’s representative in Israel who had prepared the report described above, expressed reservations after his tour of the European transit camps. In the report that he and Grushka sent to the JDC management, Vitalis criticized Jewish Agency policy in the first year of mass immigration as eschewing medical examinations (1948-49)—a practice that contributed, he felt, to the influx of many tubercular patients.

Although Vitalis did not explicitly state his opinion in the report, the document clearly indicates that Israel should either reconsider unlimited immigration of the sick or somehow take suitable measures to prepare for their arrival. He based his recommendation of preparation for the sick immigrants on the precedent set by various aide organizations operating in Europe, including the JDC. These conducted medical examinations of Holocaust survivors prior to their emigration and sought local hospitalization for those in need of treatment. Despite these measures, Vitalis worried that if Israel made no such policy of its own, the refugee populations of the dismantled DP camps would arrive in Israel en masse regardless of both their medical status and the state’s ability to care for them.

The JDC’s readiness to conduct medical classification among Holocaust survivors in the DP camps in Germany prior to immigration, in order to postpone the arrival of the sick and to care for the tubercular in venues outside of the State of Israel, was also discussed widely in the Coordination Institute. The Institute supported the solutions offered by the JDC and was inclined to transfer to it the responsibility for care.

On 18 May 1949, the Knesset conducted the first broad discussion of what was labeled the health and hospitalization situation, a discussion
carried out in collaboration with the Finance Committee and Minister of Health Shapira.\textsuperscript{45} The discussion addressed, primarily, the need to determine a government position regarding admission of sick immigrants to the country, but the discussants found they first had to confront the issue of the selection already in practice.

It should be noted that during this period, medical examinations of candidates for immigration were already conducted, but the data gathered had no connection to immigration permits; the information was used only to record an individual’s health status and to plan his or her medical care. Thus, for instance, serologic tests documented the incidence of venereal diseases among Holocaust survivors in the DP camps in Italy and in camps housing immigrants in Poland and Romania.\textsuperscript{46}

In his initial contribution to the discussion, Shapira, who was responsible for reporting on the prevailing status of health matters in the country, stressed the threat posed by unfettered immigration and noted those efforts the Health Service already made to screen arrivals for dangerous health problems. He warned that with the mass stream of immigration, two main problems “…hospitalization of those with tuberculosis and the mentally ill—have worsened to a very dangerous degree….In regard to medical services all our budgetary calculations have proven false…in that the torrent of immigration decimates all calculations.”

Shapira went on to explain that “The [Health] Service attempts to prevent the immigration of sick persons, and there are preliminary medical examination, and there is supervision.” These measures were, however, inadequate, as he noted: “among the immigrants rushing to immigrate to the country there are no small numbers that have learned to overcome all the checkpoints and they are arriving by all sorts of avenues.”\textsuperscript{47} Not least among these were the Holocaust survivors in DP camps in Germany, who heard with considerable fear the rumours of these restrictions. Since most had undergone medical selections in the concentration camps, these demands undoubtedly aroused painful memories. Many tried to avoid the examinations as a consequence and sought ways to bypass the Jewish Agency.\textsuperscript{48} In his report, Shapira further detailed the budgetary strains in which the Ministry of Health found itself and emergency plans the Ministry had adopted to cope with hospitalization needs.

Shapira’s revelation that the Health Service endeavored to prevent the immigration of the sick sparked angry responses from Left and Center parties, but for opposite reasons. Hana Lamdan, a representative from the left-wing Mapam party, said that she was “very saddened” by the proponents of these measures: “In recent days,” she said, “there are all sorts of articles appearing in the press expressing the same tone: Instead of bringing immigrants and not preparing beds for the sick ones in hospitals, it would be far better not to bring them at all.”\textsuperscript{49} At the other end of the spectrum, representatives from the General Zionists attacked
the Minister of Health for the weaknesses in the selection policy. Party MP Shoshana Persitz argued that the Immigrant Health Service should be required to carry out a rigorous medical examination of all immigrants arriving in the country and insure that not one of them would evade the eye of the Health Service.

Forced later in the debate to clarify his initial position, Shapira articulated one of the fundamental points of the intermediate stance, pointing out “regulation of immigration and closing immigration are miles apart.” He also argued that the government should, “for the time being, not permit bringing sick persons to the Land of Israel, but to seek a way together with the JDC to cure them abroad.” And he concluded by correcting the prevailing misperception of the selection policy already in effect, absolving the government from responsibility for its implications when he stated unequivocally that “there is no directive to this effect.”

Although Shapira managed to lower tensions within the Knesset for awhile when he insisted that no overall official directive existed for conducting a selection of immigrants on medical grounds, the government nonetheless had to deal with another incarnation of the argument—a public debate manifested in the press. Shapira’s description of shortages in hospital beds and the details of the Knesset debate received broad coverage in the press, where the public raged over possible regulations on immigration. In April and May of 1949, Ha’aretz journalist, Arieh Gelblum, printed a series of articles under the headline “I Was a New Immigrant for a Month.” Gelblum described in stark terms the distress of the immigrants in the Israeli transit camps, as well as the general absence of adequate health systems. He also addressed the issues of medical restrictions and possible regulation of the flow of immigrants. Specifically, Gelblum’s writings raised the specter of ethnic bias: he portrayed North African immigrants in particularly insulting terms. When David Zakai, a leading journalist and senior editor of the ruling socialist party’s newspaper, Davar, criticized this aspect of Gelblum’s articles, the discussion flared into a fierce political controversy.

Later in May, the growing tension brought Dr. Meir, just appointed Director General of the Ministry of Health, to publish an open letter in Davar. He hoped that by clarifying the ministry’s position he could ease the tensions. Like Shapira, Meir tried to explain the difference between regulation and restriction, casting the former in more benign terms: “We are not dealing with quotas for immigrants but with regulating immigration, and anyone who says that all regulation of immigrant means restrictions on immigration is merely admitting our utter failure—a sign that [the speaker] feels despair and believes that there is no possibility of regulation and therefore it is essential to restrict immigration.”

In order to illustrate for his readers the danger of forsaking regulation altogether, Meir presented some possible scenarios:
...in the end we will eventually reach the limit: another 10,000 will be crammed into the camp and 2,000 will leave, and again 10,000 will enter and again 2,000 will leave and after that what will be? Isn’t it more logical to do things in advance, before catastrophe strikes? The same person from Bulgaria diagnosed with active tuberculosis in his country of origin who has nevertheless been sent to Israel, and the same Yemenite child brought by plane with active tuberculosis—I don’t know if it’s possible and if their arrival should have been delayed, but one thing I do know is that before sending them to us, hospital beds must be prepared for them. If we haven’t done that, we are committing a sin against the immigrants and against ourselves.  

THE “SHAAR ALIYAH” [GATEWAY TO IMMIGRATION] CAMP

In January 1949, while the provisional government debated whether to conduct selection on medical grounds prior to immigration, Dr. Giora Yoseftal, Director of the Immigration Department of the Jewish Agency, proposed the establishment of a central processing camp in Israel for new arrivals. Yoseftal anticipated that the concentration of immigrants in closed camps, even in Israel, was liable to raise moral quandaries. Nonetheless, he understood the need to provide a process for a more carefully monitored and graduated absorption of new immigrants into the Israeli population. To serve this purpose, two abandoned British army camps were combined. In March 1949, concurrent with the initial debates in the Knesset, Israel opened the Shaar Aliyah [Gateway to Immigration] Processing Camp.

The plans for the camp called for it to process waves of 4,000-5,000 immigrants at a time. In theory, each shipload of new arrivals would go directly to the camp for immediate registration, examination, and classification. The sick would be sent to hospitals and the healthy to makeshift accommodations in tent camps and villages of capable workers. The processing schedule would operate on cycles of three to four days: the last 5,000 would be fully processed and on their way out as the next 5,000 came in three days later.

Medical classification of the immigrants in the camp was in the hands of the Immigrant Health Services. It processed individuals in order to locate the chronically ill and those with contagious diseases who could constitute a public health threat. An immigrant was prohibited from leaving the camp without completing the medical examination. Medical screening had a necessarily limited scope, focusing on the diagnosis of tuberculosis, syphilis, gonorrhea, trachoma, and ringworm. For this purpose, two minograph devices for chest x-rays and a serological laboratory for blood tests were opened. For expediency’s sake, the authorities determined that other tests and general classification could take place at local clinics in the areas where immigrants would reside after leaving.
the camp. The chest x-rays and blood tests were conducted by the General Health Fund, in hope that these measures would prevent a situation where an immigrant carrying a contagious disease would stay in the camp without examination. The Fund took upon itself to submit test results within 24 hours in order to locate with maximum speed any tubercular individual who constituted a public hazard. The Immigrant Health Service also administered vaccinations against typhus and smallpox.

The plan immediately encountered severe problems. Thousands of people instantly flooded the camp beyond capacity. They remained for weeks and even months at a time, most kept there due to illness or the simple lack of options for work outside the camp. Its resources already overwhelmed, the camp could not maintain decent living conditions for its inhabitants. Yehuda Weisberger, director of the camp, captured this catastrophic state of affairs:

Due to crowding, it was impossible to maintain elementary sanitary conditions, the camp was inundated with mosquitoes and flies, mice and rats, the toilets and the sewage system overflowed and in the dining hall filth and leftovers were found in every corner....The immigrants were under lock-and-key, behind barbed wire, with armed police guarding them. The crowding in the wooden and stone barracks the British army had left behind reached at times cruel proportions. They stood in long lines three times a day merely to receive a food ration. Lines snaked for kilometers around health and customs services. Often the immigrants were forced to stand for hours until their turn came to use wash-up facilities....There was not always a large enough water supply, and often there were power outages, and at night the camp was under total blackout....We couldn’t provide the immigrants with housing, even temporary accommodations.

While two-thirds of the immigrants left the camp within a week of completing medical examinations and registration procedures, the remaining third became a growing load that clogged processing and severely encumbered operation of the camp. From an inspection carried out by the director of the camp during his first days at his post, it became evident that hundreds of immigrants had not gone to the registration committee and had not appeared before the classification committee.

An ongoing shortage of medical staff contributed to the problems. In general, Israel suffered from a shortage of nurses, and the number of pediatricians prepared to work in the camp was small. The General Health Fund succeeded in mobilizing three pediatricians who carried out weekly visits in Shaar Aliyah. The station conducting the examinations in the camp had a staff of twenty-one personnel in the spring of 1949, including only one doctor. Attempts to overcome the shortage of nurses involved use of untrained personnel who were not always able to provide the proper treatment. According to Leah Weisberger, director of the isolation rooms in Shaar Aliyah, the hospital attracted a number of questionable
caregivers who were caught stealing and who callously neglected hygiene guidelines and children in their care. On the other hand, firing problematic staff could not ensure an improvement in the quality and often caused more trouble until a new employee could be found.

In order to pressure immigrants to hasten completion of their medical checkup, camp procedure allocated meal tickets according to an individual’s progress through registration and medical examinations. Only immigrants who had to delay leaving the camp for justifiable reasons, such as parents of sick children, continued to receive unrestricted support.

Separation of ill immigrants from their families severely disrupted processing, since the relatives usually refused to leave the camp, choosing instead to remain until the ill family member was well or was transferred to a treatment framework outside the camp. Immigrants found to carry a contagious disease went directly into isolation in special quarters. Sick children, separated from their parents, were hospitalized in special children’s wards. Tubercular patients in need of hospitalization went to the Tel Hashomer Military Hospital outside Tel Aviv, which had established a special TB ward for this purpose. The mentally ill and disabled also went to special frameworks that were financed by the government and the Immigrant Health Service or were funded by the General Health Fund.

Staff in the isolation wards for children in the camp testified that the primary difficulty was not the medical work but gaining the trust of the parents—which they needed in order to convince the parents to hand over their children for treatment. Leah Weisberger described the situation they faced:

We were foreigners in their eyes. They didn’t trust us and their past experience had taught them not to trust even [fellow] Jews….The fear was clear in their eyes. When we finally got a child or a sick infant we were often filled with emotion in the face of terrible scenes. The parents were filled with despair as if they were being separated from their children forever. The phenomena was difficult and painful, but understandable for the sick infant or toddler of two-three years embodied all their new life, all the hopes and desires to rebuild their demolished family, and most of the children that came then were children of second marriages after their first children were lost in the Holocaust.

The emotional distress of immigrating and quarantine in the camp more than once sparked violence incidents, particularly toward camp staff on the part of enraged immigrants. The classification committee had to operate under the protective presence of guards and police for fear of bodily harm. More than once employees were struck by immigrants and sometimes had to flee from enraged mobs. In other cases police had to remove immigrants who refused to leave after months in the camp. Fistfights broke out among the immigrants themselves, many along ethnic lines, the upshot of cultural differences and the emotional and physical pressures of camp life.
Difficulties notwithstanding, the processing system succeeded in examining and caring for some 100,000 immigrants during the year 1949. From March to June 1949, the General Health Fund conducted more than 30,000 minographs and 29,000 blood tests. Yet the difficulties in the work of the Shaar Alyiah Camp convinced the Israeli government that they needed to find a better way to conduct medical selection of the immigrants.

Despite the advice of those most closely associated with Israel’s health care system and the health of potential émigrés, the debates within the government and public discourses had not produced any strict guidelines for medical selection in 1949. The decision that did come—in January 1950—reflected the desire to fend off pressure from those in favor of selective immigration. This compromise came from Yitzhak Rafael, who served concurrently as Head of the Coordination Institute and the Immigration Department of the Jewish Agency. Previously, Rafael had held firm for unfettered immigration. He had maintained that, because of political pressure and the dangers facing Jewish communities awaiting immigration in Eastern and Central Europe and in the Middle East and North Africa, Israel could not apply across-the-board restriction policies on medical or any other grounds (such as age). Therefore, according to Rafael, deliberations on setting such general policies were superfluous. Nevertheless, in light of political circumstances, Rafael agreed to head a committee to examine the situation, which resulted in the January 1950 decision. This resolution declared that unfettered immigration would continue but also that no one would be prevented from immigrating to Israel, except due to medical or grave moral reasons. Anyone who had to immigrate to be rescued would be brought in; all restrictions would be waived for anyone in danger for his or her life.

Despite these measures, proponents of regulation continued to press their case and demanded a hearing within the government. In consequence, in May 1950 Rafael’s directive was amended and broadened: all immigrants were required to undergo a medical examination prior to immigrating. In practice, however, little changed: only a handful of immigrants were held up.64

THE LAW OF RETURN

The gap between letter and practice persisted even as the Law of Return,65 passed unanimously by the Knesset in July 1950, made Rafael’s decision obsolete. The Law of Return in some ways officially narrowed the gateway for new immigrants to Israel. Declaring oneself a Jew no longer sufficed; potential immigrants had to prove their identity through birth and genealogy. The Law also addressed medical criteria for entrance: an individual could be prevented from immigrating “if the
Minister of Interior was convinced that the applicant...was liable to endanger the public health or the security of the state....The explicit restriction in the clause...would apply also to receipt of an Immigrant Certificate." Although the Law gave exclusive authority to the Minister of Interior—whose role at the time was filled by Minister of Health Shapira—to foreclose an individual’s entrance into Israel, it did not specify the steps the Jewish Agency, or any other organization engaged in immigration, should take to locate those immigrants who posed a danger to public health. Theoretically, the authorities could apply this clause to thousands of immigrants with active tuberculosis who had already arrived and to many others awaiting entry. For the most part, however, the health clause of the Law existed in writing only: among the tens of thousands who came to Israel during this period, only several dozen applicants were rejected on medical grounds alone, and only a handful were returned to their countries of origin due to health reasons. In comparison with the stringent medical criteria adopted by the Jewish Agency in the 1920s, when hundreds of sick immigrants were sent home, this policy was relatively flexible.

In September 1950, word reached Israel of the dreadful circumstances of Jews awaiting immigration from Yemen. Several months previously, the route out of Yemen to Aden—a nation still under British control—was closed, effectively blocking escape. By September, thousands of Jews who had already set forth from their homes had encamped near the border, without any assistance. When the border opened, the refugees flooded into transit camps in Aden; they were mostly in poor health, suffering from ringworm, trachoma, malaria, and tuberculosis, and some were close to death. International authorities asked Israel to send medical aid and to arrange as swiftly as possible to receive the immigrants before the gates would again close. In the following months up to 50,000 immigrants arrived in Israel. This population included a large number of children and elderly and many individuals who were disabled, frail, and chronically ill. The question of their health status and the ability of the Israeli health system to care for them did not arise in the government or in popular discussion at all. Political and human distress was the determining factor, and the possibility of selection on medical grounds according to the Law of Return was not invoked.

Yet quite soon after the Yemenite immigration, the medical selection debate once again resurfaced. In November 1950, Dr. Haim Sheba, head of the Military Medical Service, replaced Meir as Director General of the Ministry of Health. Immediately upon assuming his post, Sheba propelled the issue of medical selection onto the public agenda. He felt strongly that Israel must set in motion a wholesale selection process on medical grounds without exception and that all sick immigrants should remain abroad until cured. In order to emphasize the danger inherent in
totally unfettered immigration, Sheba argued that a high concentration of those ill in body and soul would jeopardize the future of Jewish community in Israel. To support his argument, he used examples from genetic theories which purported to show national gene pools weakened through a lack of genetic vigilance. The eugenic origin of this theory is of course apparent. He quoted, for example, the work of Stevenson, an English geneticist who claimed Scotland had lost its greatness because it had not taken care to preserve its intellectual manpower.

Sheba, like Meir—his predecessor in the Ministry of Health, was the graduate of a Viennese medical school during the interwar period. It would appear that Dr. Sheba was even more radical in his call for medical selection than Dr. Meir. Sheba’s policies had a decisive influence in adoption of stricter medical selection criteria. It should be noted that Sheba was very close to Ben-Gurion, and that he held Sheba’s opinions in high regard. Moreover, with Sheba’s appointment as Secretary General of the Ministry of Health, the demographic composition of immigration to Israel began to change as European DP camps emptied and greater numbers of Jews from Arab countries arrived.

Sheba’s selection policy was patently manifested in the case of the Jews of Cochin. Confronted with potential immigration of the Jews of Cochin, India in 1951, Sheba issued an unambiguous directive canceling plans to bring in the entire community, claiming that they were inflicted with Filariasis and that their arrival could spread the disease throughout Israel. Sheba only rescinded his objections after a year, when the disease had been eradicated among the Cochin community. He did not alter his belief that medical selection should be applied in a wholesale manner.

It would be overly simplistic to suggest that Sheba’s position on medical selection was purely culturally motivated. As can be seen in the example of the Ministry of Health-led campaign against dermatological and venereal diseases in 1950-51, his views were largely influenced by epidemiological data. In this case the population examined encompassed immigrants from a wide array of countries, with no discrimination between the different places of origin. Nevertheless Sheba’s outlook on public health issues, like that of many of his peers, was indeed paternalistic and viewed medicine as an important tool in the Israeli melting pot. Thus, in light of Sheba’s approach, a conflict of cultural values was almost inevitable.

Sheba bore considerable influence on other important leaders in the government as the necessity of his rigorous position became more apparent. According to Yitzhak Rafael, Sheba’s unprecedented influence on David Ben-Gurion weakened to a large extent Ben-Gurion’s previously enthusiastic support for unfettered immigration and contributed to harsh disputes over the issue. Sheba also won the ear of Dr. Giora Yoseftal, Head of the Absorption Department of the Jewish Agency. Like
others, Yosef Tal did not easily ally himself with Sheba—he did so only after much hesitancy and even then only after he was convinced that the medical system in Israel would crash if the influx of sick immigrants was not regulated.

These deliberations played out on the backdrop of the difficult conditions of the new Israeli State that tried to cope with housing and tending to the new arrivals. In the summer of 1950, in response to the arduous economic situation in general, and of the immigrant population in particular, the State of Israel decided to establish immigrant neighborhoods in the vicinity of cities and well-established agricultural villages, in order to supply housing and employment opportunities for the newcomers. These transit camps, or *maabaro* were thought to be the seeds of permanent villages for future immigrants.

The terrible conditions in the *maabarot* were blamed on the policy permitting large-scale and unregulated immigration. This discussion, just as before, focused on the dilemma of mass versus selective immigration. Newspaper reports on the demography of the immigration led to public criticism and the resurgence of the allegation that wealthy, well-established families stayed in their countries of origin while trying to get rid of the ill and disabled by sending them to Israel. Reports on the worsening political situations in Persia and Libya and the need to quickly bring in the refugees out of fear that they would soon be forbidden from leaving, did not assuage the critics. Immigration officials claimed that the absence of medical regulation together with the preference of wealthy families to emigrate to other countries (i.e., Canada, France, Australia) instead of Israel was resulting in a “negative selection.” Even Yitzchak Rafael, one of the leading supporters of unobstructed immigration admitted that 80% of the immigrants in 1951 had come from countries in dire conditions, had undergone no medical examinations, were in very poor health, and were thus taking a heavy toll on the Israeli health care system.

The first step towards applying restrictions was the establishment of medical criteria for selection. In November 1951 the executive of the Jewish Agency gathered for a series of meetings to determine a plan for immigration and to appoint a committee that would be directly responsible for immigration issues. The members of the executive were evenly divided between advocates and critics of medical selection. Both sides tried to tip the scales in their favour by soliciting the support of Prime Minister David Ben-Gurion. Ben-Gurion was distressed at the difficult absorption process that the immigrants had undergone as well as the particularly poor state of health that these immigrants were in, as opposed to those of earlier years. As a result, in 1951 Ben-Gurion was convinced that some sort of restriction of immigration had become a necessity. The moderation of his position made it possible, to a certain extent, to form the new immigration policy.
On November 18th, at the concluding meeting of the Jewish Agency executive, several measures were taken. Firstly, it was decided that applicants for immigration would be subject to severe restrictions. Secondly, a list was drawn up of countries of origin whose émigrés would be particularly investigated. Finally, medical and social criteria were established for determining immigration candidates. The medical criteria were such that immigrants from North African countries, Turkey, Persia, India, and Western and Central European countries would be allowed to immigrate only following a thorough medical inspection by an Israeli physician. Furthermore, it was decided that 80% of the immigrants should be under the age of 35 and that all applicants, except for those who were skilled in fields the country needed, would have to be committed to working in agriculture for two years. In response to Ben-Gurion’s request a section was added to clarify that in cases of “rescue” these stipulations would not be enforced. The members of the Jewish Agency had judged that people under the age of 35 would be healthier, and thus by limiting the number of people over 35 to 20% there would be less need for medical attention. The medical selection policy established in 1951 was begun as the demography of immigration was undergoing a radical change. It was not Jews from Arab countries, and not Holocaust survivors, who made up the majority of immigration.

It is hard to gauge the impact the medical selection had on trends and the scope of immigration in the first years of the state. Opponents such as Yitzhak Rafael claimed that the selection process dissuaded various communities from even attempting to immigrate to Israel, and he felt that it contributed more than any other factor to the cessation of immigration to Israel at the time. Others argued that selection had only a marginal effect on the magnitude of immigration, ascribing the decrease to political circumstances or to the overall exhaustion of the reservoir of potential immigrants in certain exit countries. Despite the differences of opinion, at the beginning of 1952, when it became evident that the scope of immigration had dropped considerably, the Coordination Institute reviewed the question of selection on medical grounds and conducted a new round of deliberations in March 1953, headed by Ben-Gurion. In response to Ben-Gurion’s opinion that selection on medical and socioeconomic grounds was having a negative impact on the desire to immigrate, particularly among North African Jews, Sheba suggested significant liberalization vis-à-vis the health status of candidates for immigration; he made exceptions for only a few specific diseases, such as tuberculosis or syphilis, in which case the individual could enter Israel after the condition had been fully cured. The discussions also established compound criteria for bringing in sick persons as part of a supporting family unit. When he summarized the session, Ben-Gurion made it clear that “If the entire family is immigrating, and there is a per-
son whose livelihood must be provided for, this will not be used to postpone the immigration of the entire family.”

EPILOGUE

Throughout the course of the 20th century, questions of health and immigration have gained a greater and greater influence in determining how immigrants are received in various countries—questions that are often fueled by fear of the foreigner and the other. In more than one case, medicine has served as a “roadblock” for preventing the entrance of certain individuals, but in the final analysis those immigrants who were denied entrance into the various immigration countries because of medical reasons were actually few in number. It is more as an assimilation tool for immigrants into local society and as a litmus paper of the apprehensions of the absorbing society that medicine plays so important a role. This is not to say that public health considerations have not been relevant or justified, but history has shown that images of disease can spread rapidly, leading to alienation and tension. One of the test cases used to examine these issues is the question of medical selection of immigrants.

The uniqueness of the Israeli case in regard to medical selection of immigrants lies in the tie between Zionist ideology and the desire to build a new society, under conditions of mass heterogeneous immigration. The tensions this situation created were reflected both in Israeli society as a whole, and specifically within the public health policy for immigration. The medical selection of immigrants to Israel, first initiated in the 1920s under the British rule, took on a polemic bent primarily after the establishment of the State. The genuine public health concerns of a young state absorbing tens of thousands of immigrants conjoined with the generally ambivalent attitudes towards the immigrants sparked tensions between immigrants and the absorbing society. The Israeli health system drew on American and European wellsprings—including the problematic tendencies towards eugenic thought that most local doctors had been educated in during the course of their medical studies abroad. These traditions meshed with the Zionist ideology which sought to build a new nation and a “new Jew.”

According to sociologist, Moshe Lisak, medical selection was not designed to limit the number of Jews of non-European origin as some have claimed; rather, it was employed to ease the burden on an absorption machinery that was unprepared to care for so tremendous an influx of newcomers. The traumas of immigration that resulted were, in essence, the upshot of the failures of an absorption and organizational system which had continued to operate according to regulations that had worked in the 1920s and 1930s, in a very different context. The failure came with the inability to grasp and cope with the change that had taken place in the scope and composition of the immigration.
In her book, *Immigrants in Turmoil*, Dvora Hacohen, a historian of the mass immigration to Israel, emphasizes that those responsible for organizing the immigration at the points of origin in the Diaspora held tremendous personal power in interpreting medical restrictions on immigration. To a large extent, action and policy hinged solely on their decisions in the field. Therefore one should evaluate selection policy on two separate planes: the first—on the policy-making level, the second—on the implementation level. Hacohen asserts that most of the on-site immigration organizers in the Diaspora tended to be very flexible in interpreting restrictions while those who actually absorbed the immigrants in the State of Israel sought to stiffen the restrictions as a way of reducing the number of immigrants to manageable proportions. Thus, the controversy over medical selection was conducted not only between the immigrants and policy makers, but also between field personnel abroad and their supervisors in Israel.

Moreover, Yishai Arnon, in his study of immigration policy in the years following mass immigration—1954-56—suggests that medical selection unintentionally came at great cost. Upon receiving its independence from France in 1956, Morocco blocked the emigration of Jews. Those who had been left in transit camps due to Israel’s immigration restrictions were force to stay in Morocco for another four years until Jews were again allowed to leave the country in 1960. Nevertheless, Arnon rejects the charges that medical selection was applied on ethnic grounds, concluding that the motivations were practical. The plight of Moroccan Jewry emanated from the fact that this community was the last of the Jewish communities to come to Israel during the period of the mass immigration, by which time most of the economic and health resources had been exhausted.

While Israeli scholars suggest different possible motivations behind the medical selection in the course of mass immigration immediately after the founding of the state, all agree that the immigration process was the source of serious trauma for a large number of immigrants—a trauma that many of the immigrants themselves directly blame on the medical classification they were required to undergo. The trauma continues to accompany these immigrants to this day, and serves as fertile soil for political controversy between Left and Right, Ashkenazi Jews and Sephardic Jews, then-immigrants and then-veterans.

It is precisely this inextricable link between medicine, immigration and the core issues of present-day Israeli society that makes this subject so essential. Through examination of the role of health and medicine in the absorption of immigrants in the first years of the State a significant contribution can be made to better understanding both the complex interplay of components that helped form Israeli society as well as how these factors contribute to the problems the country faces today.
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NOTES

1 All the data presented in this work was systematically collected from the Central Zionist Archives and the State Archives of Israel in Jerusalem, the archives of the “American Joint Distribution Committee” [JDC] in New York, the archives of Kupat Holim (The General Health Fund) in Tel Aviv and the David Ben-Gurion archives in Sdeh Boker.


4 The issue of social selection was related to medical selection rules, yet was described separately by contemporary policy-makers. It will be touched upon in this work, but deserves to be explored in greater depth in future research.


6 On quarantine and immigration see Howard Markel, Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892 (Baltimore and London: Johns Hopkins University Press, 1997).


8 Markel, Quarantine; Fairchild, Science at the Borders; Peter M. Coan, Ellis Island Interviews: In Their Own Words (New York: Facts on File, 1997); and Mark H. Lai, Genny Lim, and Judy Young, Island: Poetry and History of Chinese Immigrants on Angel Island 1910-1940 (San Francisco: Chinese Culture Foundation, 1980).


10 Kevles, D.J., In the Name of Eugenics: Genetics and the Uses of Human Heredity (New York: Knopf, 1985); and Nancy Ordover, American Eugenics: Race, Queer Anatomy, and the Science of Nationalism.


12 Immigration Department of the Palestine Zionist Executive, Instructions for the Medical Examination of Immigrants, Compiled by the Health Council of the Palestine Zionist Executive, Jerusalem, 1926.

13 Central Zionist Archives (CZA), S/230/2121, List of Chronically Ill who were Returned Abroad through the Jewish Agency for Israel in the Year 1930.

14 The subject of medical selection prior to establishment of the state has yet to be examined sufficiently. The authors are in the process of a study on medical selection policy under the British Mandate. Yet clearly the issue of medical selection after the
Establishment of the state has been the subject of far greater dispute than policy during the 1920s and 1930s under British rule.


17 Devora Hacohen, *Olim be-Saara*. 

18 Coordination Institute Meeting, 1 November 1948, p. 57 BGA; CZA, S/100/502, p. 7.

19 Eliezer Kaplan (1891-1952) was born in Russia and graduated from the Faculty of Engineering in Moscow, immigrating to Israel in 1923. He was a key figure in the Israeli labour movement, serving as a member of the Jewish Agency directorate from its beginnings and as Israel’s first Minister of Finance (1948-52).

20 Coordination Institute Meeting, 1 November 1948, p. 62 BGA; CZA, S/100/502, p. 12.

21 David Ben-Gurion, (1886-1973), the first head of state of the State of Israel. Born in Poland, immigrated to Israel in 1906, was a member of the Socialist Zionist movement in Palestine during the period of Ottoman Turk rule, among the founders of the General Federation of Labour (1920) and Secretary General of the organization until 1935, as well as chairperson of the Jewish Agency (1935-48). Ben-Gurion served as Prime Minister during the years 1948-53 and 1956-63. Member of Kibbutz Sde Boker in the Negev from the year 1953.

22 Mapai, an acrostic for Israel Workers Party, was a socialist political party in Israel founded in 1930 by Zionist pioneers through the union of two Labour Zionist parties Achdut Ha-Avodah (Labour Solidarity) and Hapoel Hatzair (Young Workman). From the outset, Mapai was a dominant force in political life of the Jewish community and the labour movement in Israel. Under the leadership of David Ben-Gurion, Mapai headed all governments up until the year 1977, which brought in a non-Socialist government.

23 Mapam, an acronym for the United Workers Party, was a socialist Zionist party established in 1948 through a union of the Hashomer Hatzair (Young Watchman) movement and a splinter group from Achdut Ha-Avodah. The party was a moving force in the establishment of kibbutzim in the formative years of Zionism. In 1969, Mapam joined Mapai to form the Israel Labour Party (Ha-Avodah).

24 Many viewed Ben-Gurion’s political collaboration with the religious and avoidance of a partnership with Mapam as a tremendous catastrophe for the workers movement. Histadrut Executive Protocols, November 1949, p. 19, BGA.

25 Rabbi Haim Moshe Shapiro (1902-70), head of the Ha-Poel Hamizrachi Party a pro-Zionist religious party, was born in Russia and immigrated to Israel in 1926. An activist in the World Zionist Movement and director of the Immigration Department of the Jewish Agency (1935-45), Shapiro was one of the founders of the National Religious Party in 1956. He was a figure known for his moderate policy outlook and his championship of a partnership between the religious parties and the workers parties headed by Ben-Gurion.

26 The United Religious Front—a union of religious parties of Zionist and non-Zionist observant Jews brought together in one bloc the Mizrahi movement—a religious Zionist movement, and the HaPoel Hamizrachi a pro-Zionist party formed by religiously observant labourites, and the Poalei Agudat Israel party a non-Zionist labour party of Orthodox Jews. The Front operated as a united political entity until 1956.

27 Dr. Yosef Meir (1890-1953), was born in Poland and was a graduate of the Faculty of Medicine in Vienna. He immigrated to Israel in the 1920s and was a member of the senior management of Kupat Holim (The General Health Fund) the leading health service provider organization in Israel (established 1911), serving as the Funds first medical director from 1929. Meir was subsequently appointed director general of the Ministry of Health, a post he filled between the years 1949-50.

28 Lavon Institute-Labor Archives (LLA), 243-3-137-IV, Letter from Dr. Meir to Minister of Health and Immigration, 28 April 1949.
29 LLA, Letter from Dr. Meir.
31 It is interesting to note that in 1943, Dr. Yosef Meir, head of Kupat Holim, formulated the medical program for absorption of immigrants together with various experts who were invited by David Ben-Gurion to design the “One Million Plan”—a plan to absorb a million Jewish immigrants in Palestine. In Meir’s program there was no call for medical selection of immigrants that would prevent their arrival in the country, but rather categorization in camps established in Israel itself. Meir even draws up in detail the camp’s structure and division of tasks. See Dr. Yosef Meir: “Tochnit Refuit le-Klitat ha-Olim ha-Chadashim” [Medical Plan for Absorbing New Olim], 24 December 1943, in Dvora Cohen, Tochnit ha-Milyon, Tochnito shel David Ben-Gurion le-Aliya Hamonit be-Shanim 1942-1945 [The One Million Plan of David Ben-Gurion for Mass Aliyah in the Years 1942-45], (Ministry of Defense Publication House, 1995), p. 264-65.
34 Nachum Gross, Not by Spirit Alone. Based on hospitalization costs of 3 pounds/day, and 1.5 pounds/day for mental patients.
35 Estimations of costs written by Vitalis, p. 3; Memorandum by Dr. Grushka attached to Memorandum by Harry Vitalis, p. 4. Taking all these into account, the annual budget for medical services for immigrants that in 1944-45 stood at 40,000 pounds, would require 700,000 pounds in 1948-49. Memorandum by Dr. Grushka, p. 4. Similar financial forecasts regarding the outlay expected were also submitted in Jewish Agency reports during the same period. Joint Archives NY, Boris Pliskin files, Jewish Agency for Israel, Immigration Department, Review of the Activity of the Department from the month of Elul 1948 to Nissan 1949 submitted to the session of the Zionist Executive in Jerusalem, 1949.
38 As historian Zvi Zameret has argued, it is hard to know to what degree Ben-Gurion was truly optimistic about the state’s ability to absorb masses of immigrants from all Diasporas—or whether his public statements stemmed from a desire to project optimism to the public and from political interests in the feelings of the immigrants. See: Zvi Zameret, “Ben-Gurion and Lavon: Two Positions toward Appropriate Absorption of Immigrants,” in Dalia Ofer, ed. The Great Immigration, between Immigrants and Veterans (Jerusalem: Yad Ben Zvi, 1996), p. 78. See also p. 73 and announcement by the PM in the Knesset, on 26 April 1949 in Eli Shaltiel, ed. David Ben-Gurion: Selected Documents, Israel State Archives (Jerusalem: Government Printing Office, 1996), p. 158-61.
39 BGA, Ben-Gurion, Diary, 24 April 1949.
41 BGA, Ben-Gurion Diary, 4 March 1951.
42 Yitzhak Rafael (1914 -99) was a key leader in the Poel HaMizrachi movement, born in the Ukraine (Galitzia) and educated at the Jewish Theological Seminary for rabbis in New York. Immigrating to Israel in 1935, he was a member of the Jewish Agency directorate and head of the Agency Immigration Department between the years 1948-54. Rafael served as a parliamentarian in the 2nd to the 8th Knesset, serving as deputy minister of Health (1961-65) and minister of religious affairs (1974-77).
43 Harry Vitalis, Preparations in the Field for Hospitalization in Expectation of Increased Immigration 24 April 1949, JDC Archives, New York, Boris Pleskin files.
The early medical examination conducted in Warsaw apparently by the JDC included a physical examination, hearing and vision, chest x-ray, syphilis test, and list of vaccinations received before immigrating. See also: Health Card No. 1850 of Chana Yashinska, a new immigrant from Poland who came to Israel in the year 1950. The card was issued by the State of Israel, Ministry of Immigration and was written in Polish and Hebrew. The document was submitted to the authors by Mrs. Maya Yashinska-Finger.

44 BGA, Coordination Institute, 29 December 1948, p. 9-10; Coordination Institute, 3 March 1949, p. 47-65.

45 The debate was the initiative of MK Israel Rokach, a leader of the liberal non-Socialist-General Zionists party and mayor of Tel Aviv. See also: Working Program of the Department for a War on Venereal Diseases and Social Dermatological Diseases, Minister of Health, Social Medicine Division, 1950-51, Appendix A, p. 3.

46 In August and September 1949, Wassermann tests were carried out on 5,000 Jewish women in Romania. In Italy, 2,500 persons were examined for syphilis, gonorrhea and tuberculosis. In Poland all immigrants were checked for syphilis. In the report submitted to the Israel Ministry of Health it was cited that approximately 1.5% of those examined in Poland were found to be infected.

47 Letter from Dr. Chertok to the Minister of Health, 16 May 1949, LLA IV/243/3/61.

48 In letters sent by Dr. Chertok, a physician working in the DP camps in Germany, the doctor cited:

Some sick persons are filled with fear of their fate on German soil, and they succeed in immigrating without a permit from the Immigration Department. The fear is so poignant among inmates who lived in concentration camps that it overcomes considerations of logic and the immigrants don’t take into account the possibility of infecting others....We have to reach the conclusion that despite inspection, a not small number of sick people will arrive in the country; moreover, some of the immigrants harboring inactive clinical findings in their lungs under new economic and climatic conditions will become active carriers in need of hospitalization. If we will not prepare to isolate these patients, there is the danger the disease will spread on a wide scale.

49 BGA, Ben-Gurion, Diary, 24 April 1949.

50 The General Zionists were a centralist liberal Zionist party established in 1922 that championed a free market and limited government intervention in the economy. Among the specific statistics these MPs complained about were these: “Proper medical examinations of the immigrants as they exit the Exile is lacking. The JDC was advised to send 2,000 tuberculosis patients among the immigrants to Switzerland. They were not sent there and some of them infiltrated the State of Israel and endanger the health of the healthy. We heard there are 1,760 cases of active tuberculosis.”

51 Knesset Protocols, 23 May 1949 meeting, Volume 1, p. 552.

52 Knesset Protocols, p.552. It is interesting to note that with the first Knesset in 1949, a new theme emerged with some members charging that the government was applying medical restrictions on an ethnic basis. Both Bechor Shitrit and Eliahu Eliashar claimed that immigrants from North African and Asian countries were being discriminated against. Shapira also took issue with the claims of MK Shitrit, who claimed that the Ministry of Health enforced medical restrictions primarily with non-European Sephardic, especially those from North Africa and Asia.

53 Arieh Gelblum, “For a Month I was a New Immigrant,” Haaretz, 18 April 1949; 24 April 1949; 29 April 1949; 2 May 1949.

54 Davar, 24 May 1949, p. 2

55 Davar, 24 May 1949, p. 2

56 Giora Yoseftal, (1912-62) was an activist in the Jewish labor movement in Germany, a graduate student and doctoral graduate of the Faculty of Law in Berlin. He immigrated to Israel in 1938 and joined the British army. He served as head of the Immigration Department of the Jewish Agency between 1945-52, and as a member of the Agency’s directorate. In 1960 he served as Minister of Labour and in 1961 as Minister of Housing and Development.
The detention camps in Cyprus were established by the British to keep under lock-and-key all illegal Jewish immigrants who attempted to reach the shores of Israel between the years 1945-48 without entry permits, primarily by running the British blockade in ships. The camps housed thousands of immigrants under harsh living conditions.

Chest x-rays were carried out on children from age 8 and up. Blood tests were done on all immigrants age 15 and over. “Insurance for Immigrants,” Al ha-Mishmar, [daily newspaper] 4 April 1949, p. 2.


Report on the Activity of the Aliyah Department, Kupat Holim Executive, 4 July 1949 CZA, IV 243-3-63, Portfolio 24/1, p. 2-3.


David Shachar, Regime and the State of Israel (Tel Aviv: Yasod, 1993), p. 126.

Shachar, Regime, p. 126.

Dr. Haim Sheba (Shiber), (1908-1971) was born in Romania and graduated from the Faculty of Medicine in Vienna, immigrating to Israel in 1933. He worked as a physician in Kupat Holim hospitals and served as a military doctor in the British army during World War II. During Israel’s War of Independence, Dr. Sheba served as commander of the Israeli Military Medicine Service, as director general of the Ministry of Health between the years 1950-53 and as head of the Tel Hashomer (today, Sheba) Medical Center, outside Tel Aviv.

Bondi, Every Man’s Physicians, p. 153.

Bondi, Every Man’s Physicians, p. 153.

The immigration of the Jews of Cochin (India) was postponed until February 1954. Only after their medical status was finally clarified, their immigration was approved by Dr. Batish, director general of the Ministry of Health. BGA, State Archives, Prime Ministers portfolio, 5388/10, Summaries of the Coordination Institute meeting in the PMs office, 18 February 1954.

At the time, tests for syphilis were conducted in immigrant encampments in Romania, Poland, Italy, Tunis and Casablanca. On the other hand, Yemenite immigrants were not subject to the same checkups in transit camps in Aden, but only after their arrival in Israel in order to formulate a treatment program that would prevent spread of the disease.

BGA, Diary, 2.6.1952, Sede Boker. Ben-Gurion wrote in his diary:

Sheba grumbled about Rafael from the Jewish Agency that he violates decisions taken by the Coordination Institute concerning medical checkups by the Ministry of Health, bringing into the country blind and paralyzed persons who become a burden on the public. In Persia he gathered together a motley crowd and brought them in without a permit. A person whose both legs are paralyzed was brought from North Africa. I requested he bring me the material in writing and I’ll approach Rafael.


Private Archives of historian Ruth Bondi, Ramat Gan, Dr. Itzhak Rafael Protocols.


Hacohen, Olim Be-Seara.