

Health in interwar Palestine: Ethnic realities and international views

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SUMMARY

1. —Health situation in Palestine. 2.—Healthcare systems in interwar Palestine. 3.—Conclusions.

ABSTRACT

This paper analyses the developments of the separate Jewish and Arab health systems and health realities. It is found that the activities of charitable institutions, the attitude of the British mandate government and different traditions of medical policy all played a part in the emergence of two separate health worlds. The influx of foreign funding for private health institutions, in particular, played a prominent part in establishing different service levels of healthcare for Jewish, Arab Christian and Arab Moslem communities. Thus, the medical sphere both reflected and interacted with wider political events.

Palabras clave: Palestina, sistemas asistenciales, estadísticas de salud, etnicidad

Keywords: Palestine, health care systems, health statistics, ethnicity

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1. HEALTH SITUATION IN PALESTINE

Public health in Palestine in the early twentieth century started from difficult conditions. Throughout the nineteenth century, the area was considered backward and known to be plagued by epidemics of malaria, cholera and smallpox(1). The Arab rural population (i.e. the majority of inhabitants in Palestine) were almost entirely illiterate and enjoyed a life-expectancy of merely 35 years, due mainly to the very high infant mortality rate(2). After 1914, the First World War ravaged the country and further exacerbated health conditions. The Arab majority, susceptible to compulsory recruitment, was struck particularly hard, but, indeed, all groups suffered from disease, famine, emigration and demoralizing deportations, resulting in population decline(3). Between the world wars, the main health problems were malaria, measles, pneumonia, trachoma, hookworm, tuberculosis, and typhoid fever. While mortality statistics are incomplete and probably of doubtful reliability, they indicate the dominance of infectious diseases as causes of death, as is to be expected in a relatively undeveloped area prior to the epidemiological transition(4). (See Table 1). The biggest killers appear to have been pneumonia and measles, both of which were formidable lethal diseases also in nineteenth and early twentieth century Europe (5). Tuberculosis was apparently little noticed

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- (1) TESSLER, Mark. *A history of the Israeli-Palestinian conflict*, Bloomington/Indianapolis, Indiana UP, 1994, p. 124.
 - (2) SHEPHERD, Naomi. *Ploughing sand. British rule in Palestine 1917-1948*, London, John Murray, 1999, p. 126.
 - (3) SHVARTS, Shifra. *The workers' health fund in Eretz Israel. Kupat Holim, 1911-1937*, Rochester, University, 2002, p. 70; TESSLER, note 1, p. 145; SMITH, Charles D. *Palestine and the Arab-Israeli conflict*, New York, St. Martin's Press, 1992, pp. 68-69; For the Jewish community, Shifra Shvarts cites a decline from a prewar population of 88,000 to 57,000 people in 1919. SHVARTS, Shifra. The development of mother and infant welfare centers in Israel, 1854-1954. *Journal of the History of Medicine and Allied Sciences*, 2000, 55 (4), 409-410.
 - (4) See REPORTS by His Majesty's Government in the United Kingdom of Great Britain and Northern Ireland to the Council of the League of Nations on the Administration of Palestine and Trans-Jordan (hereafter Report) for the years 1921 to 1938.
 - (5) See HARDY, Anne. *The epidemic streets*, Oxford, Clarendon Press, 1991.

TABLE 1
Number of deaths from some causes of death

	1921	1922	1927	1928	1929	1930	1931	1932	1934	1935	1936	1937	1938
Measles			324	1,056	525	336	731	337	301	224	669	175	
Typhoid				71	65	64	76	119	185	204	194	155	
Pneumonia				354	409	377	414	433	477	411	390	388	
Malaria	113	65											
Tuberculosis							215				201	234	211

Source: The data in this and all the following tables and figures (unless stated otherwise) have been compiled from the British Governmental Reports to the Council of the League of Nations on the Administration of Palestine and Transjordan of the years 1921 to 1938.

at first but emerged as a disease of «considerable endemic importance» during a special investigation into social diseases, including Tb, carried out between 1931 and 1933 (6).

Given these difficult circumstances, the development of public health in interwar Palestine was in some ways a success story. By the end of the Mandate life expectancy had risen by fifteen years. Substantial public health programs, including widespread inoculations, helped bring infectious diseases under control (7). This progress is reflected in the detailed vital statistics, which British reports began reporting in 1927. Except for an unexplained gap in 1935, it is possible to follow crude death and infant mortality rates until 1938. (See. Figs. 1 and 2). A comparison with average European rates after 1932 underscore both to what degree Palestinian death rates were higher than in Europe at the outset and their subsequent positive trend. While the average European death rate remained fairly static around thirteen deaths per 1000 living persons, the Palestinian average stood at around twenty-eight in 1927 but declined to fifteen until 1938. Evidently, in the course of a decade, mortality differences between the average

(6) REPORT 1933, p. 138; REPORT 1935, p. 149; cf. REPORT 1932, p. 118; REPORT 1933, p. 134, note 4.

(7) SHEPHERD, note 2, p. 126.

Figure 1.—Crude death rates.

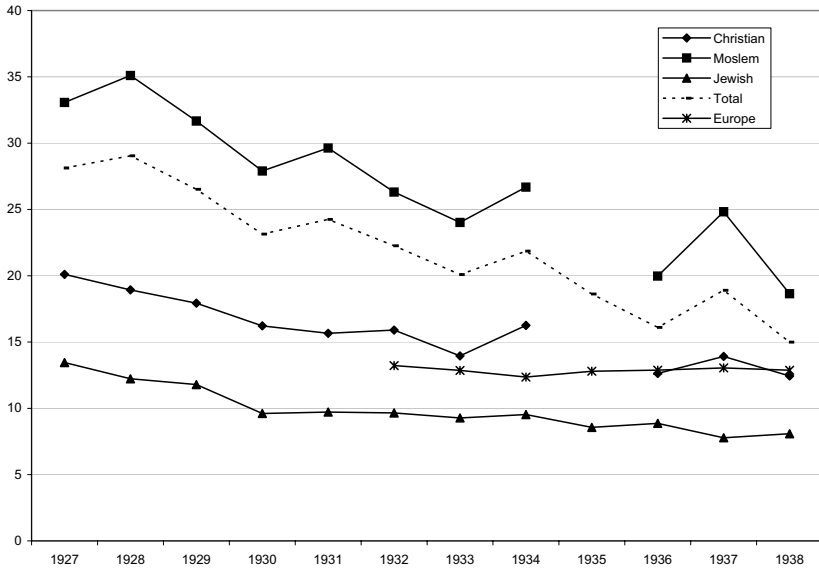
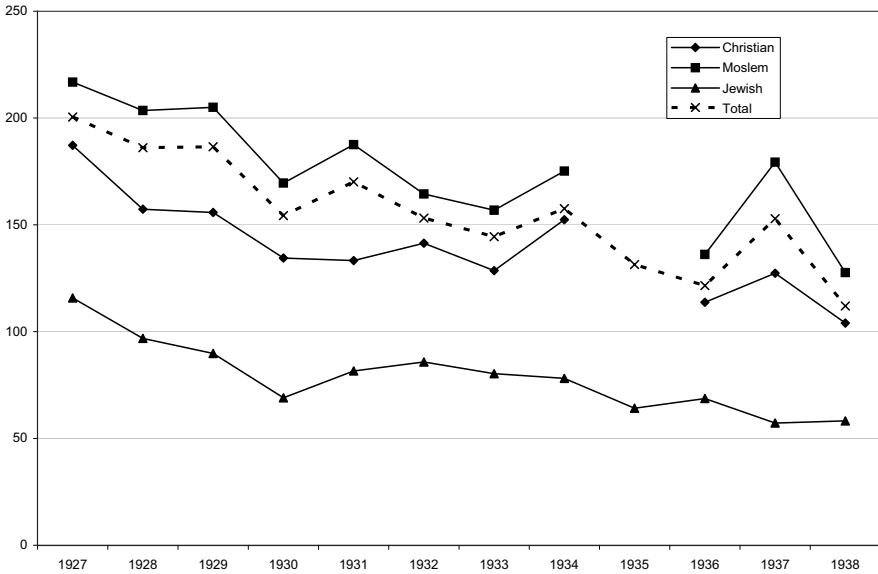


Figure 2.—Infant mortality rates.



European region and Palestine dwindled to insignificant levels. This development indicates an obvious and drastic improvement in Palestinian public health during interwar years. However, this comparison of aggregate data is grossly misleading about the true nature of life and death in Palestine because it obscures the substantial differences between the various religious and ethnic groups.

The exact ethnic composition of Palestinian society and its development in time is difficult to establish. Exact data for the pre-war population are not available. Calculations rely on Ottoman figures, which must be adapted to later Palestinian boundaries and must compensate for structural undercounting (8). Data during the British mandate are slightly more reliable but also suffer inevitable inaccuracies. The last census was taken in 1931. Subsequent demographic data are estimates, based on birth and death registration and estimates of immigration, all of which were inexact. They are, however, sufficiently accurate to gain a general impression. According to the 1921 British census, a total of 752,048 people lived in Palestine. Of this group, 78.34% were Moslems, 9.5% Christians (making an Arab majority of 87.84%), and 11.14% were Jewish. The following twenty years saw a rapid increase in the general population. By 1942, it had doubled to 1,620,005 people. Relatively, the Jewish community increased most, so that its proportion of the population grew from just over eleven to 29.90%. Meanwhile, the Moslem percentage decreased to 61.44% in 1942, and the Christian percentage to 7.85% (9). The vast majority of the Arab population were rural, making a modest living on farming. There was a «narrow stratum of urban intellectuals», a disproportionate part of whom were Christians (10). The Jewish population was a highly diver-

(8) Frequently uncounted were Jews of foreign nationality, nomadic Bedouins, and Moslems who evaded the census to avoid the draft. Women and children are considered to have been undercounted. Consequently, estimates vary widely. For a discussion of the population issue and lists of estimates see: <<http://www.mideastweb.org/palpohtm>> and <<http://www.palestineremembered.com/Acre/Palestine-Remembered/Story559.html#Table%201>>.

(9) <<http://www.unu.edu/unupress/unupbooks/80859e/80859E05.htm>>; See GERTZ, A.; GUREVICH, D. (eds.). *Statistical Handbook of Jewish Palestine*, Jerusalem, Jewish Agency (Department of Statistics), 1947, pp. 46-47.

(10) TESSLER, note 1, pp. 131-132.

se and evolving community. It included long-time resident Orthodox Jews, a private, mostly land-owning sector and labour Zionists, and their numbers rose through several waves of immigration («aliyas»). The largest immigrant groups in the interwar period came from Poland and Russia, comprising farmers, merchants, artisans and urban professionals, secular Socialists as well as devout believers. Together they built a new Jewish society, known as «Yishuv» (11).

As obvious in Figure 1, Jewish death rates were lower than average European death rates of that period, those of Christian Arabs were slightly higher or comparable and those of Moslem Arabs were substantially higher. Interestingly, while all death rates declined during the years in question, the proportionate differences remained fairly stable. Throughout, Moslem crude death rates were more than twice as high as their Jewish counterparts. Similarly, Moslem infant mortality also reached double the rate of Jewish infant mortality rates. In both cases, the rates for Christians stood in between, with their fluctuations paralleling those of Moslems (12). These differences are striking not only for their statistical extent and consistency, but also because they seem to contradict epidemiological common sense. A considerable part of the Jewish community consisted of immigrants, whose exposure to a new disease pool naturally made them more susceptible to local pathogens. Thus, typhoid and dysentery were considered to affect mainly the Jewish community (13). But these illnesses did not seem to have a noticeable impact on mortality. Clearly, other factors must have been at work, factors that observed religious but cut across ethnic boundaries. There must have been something that divided Christian and Moslem Arabs of similar ethnic, cultural and

(11) TESSLER, note 1, pp. 185-186; SMITH, note 3, pp. 76-80.

(12) The data for Palestine derive from the respective British mandate reports. European rates come from JEGEDE, Francis; STUBBS, John. The demographic transition in Eastern and Western Europe. A comparative analysis. In: Jochen Fleischhacker; Rainer Münz (eds.), *Gesellschaft und Bevölkerung in Mittel- und Osteuropa im Umbruch*, 31. Arbeitstagung der Deutschen Gesellschaft für Bevölkerungswissenschaft, Berlin, Tagungsband [Demographie Aktuell Nr. 13], 1998, p. 55.

(13) Report 1924, note 4, p. 32; SHEPHERD, note 2, p. 136.

social backgrounds, but united Sephardic and Ashkenazi, Orthodox, Socialist and non-observant Jews. How did health form an alliance with religion? One, though not necessarily the only, answer may be found in different healthcare environments.

2. *HEALTHCARE SYSTEMS IN INTERWAR PALESTINE*

Healthcare, as always, was a function of political responsibility. The Peace Treaty after the First World War stipulated that the former Ottoman territory now forming Palestine, would be a League of Nations mandate ruled by Great Britain as mandatory power. The mandatory system of the League transformed events in Palestine from a local (Jewish-Arab-English) or bilateral (Jerusalem-London) to an international issue. As part of this internationalisation, all actors could or had to present themselves and their case to an international audience, which was obliged to take note. Indeed, while for all practical purposes the British ruled Palestine much like a colony they faithfully and regularly sent reports about their mandates to the League of Nations Mandate Commission. The Mandate Commission, in turn, forwarded the parts dealing with health to the Health Committee (14). For the most part, the involvement of the League of Nations Health Organisation (LNHO) was limited to receiving these papers. On request of the Mandates Commissions, it did, however, define the information the mandatory powers should give in their annual reports (15). This rudimentary form of standardization added substance to the reports and is, indeed, helpful for historical analysis. Within this mandatory framework, health assumed a specific place. Public health, universally recognised as a crucial good, became a litmus test for good governance. An administration which failed to ensure minimal health standards for the population under its care, could not expect to be perceived as deserving of support. This was an important factor in a situation

(14) See President of the Mandates Commission to the Secretary General, 17 September, 1923, League of Nations Archives (hereafter LNA), R 61/31174/22290.

(15) President of the Health Committee to the President of the Mandates Commission, 16 August 1922, LNA, R 61, 1/22290/22290.

when various groups held competing claims on governmental authority. Health administration competence served as a *pass pro toto*, an issue symbolizing governmental capabilities in general. This implicit function assigned different roles to the various groups involved. For the British government, health policy was a necessity of routine colonial life, and the health reports offered a means to present competent mandate administration. For the Jewish community, health similarly represented a platform on which to demonstrate a capability to handle the organisation of a state, including the extra health burden of immigration. Jewish offices acted like state bodies and, as a result, were perceived and treated as such (16). In 1924, a newly founded Board of Health, part of the Palestine Zionist Executive and composed of representatives of various Jewish health organisations, introduced themselves to the League of Nations Health Section. By letter, they explained their function and expressed their wish to exchange information with the League institution (17). They did indeed send some material on Jewish Health Work, which demonstrated that all institutions of the British Health Department had a Jewish counterpart, including hospitals, convalescent homes, laboratories and educational campaigners. In fact, Jewish were often larger, better financed and offered more comprehensive services than similar British institutions, both in therapeutic and preventive medicine (18). In short, as of the mid-1920s, Zionist authorities could give proof of complete quasi-governmental health structures. In addition, the related discourse on health issues helped ensure that Jewish inhabitants of Palestine were viewed as equals rather than «natives» and, in particular, set them apart from Arab Palestinians (19). This aspect may seem banal today,

(16) FREIMARCK, Peter. Zum Selbstverständnis jüdischer Nationalität und Staatlichkeit in Palästine. In: Helmut Mejcher (ed.), *Die Palästina-Frage 1917-1948*. 2nd ed., Paderborn, Schöningh, 1993, pp. 50-88 (60).

(17) Palestine Zionist Executive to League of Nations Health Section, 21 May, 1924. LNA, R 928, 12B/ 36859/36859.

(18) Report on Jewish Health Work, undated, LNA. R 928, 12B/36859/36859; Kahany (Agence Juive pour la Palestine) to Rajchman, 24 March 1937, LNA, R 61 77/8C/28625/1644.

(19) The danger of being confused with «natives» and the need to avoid such identification was clearly noted by prominent members of the Yishuv like David Ben-

but it doubtlessly was not in the colonial framework of the time, which conditioned people of European descent to take ethnic inequality for granted. Thus, observable Jewish health work helped increase the respectability and acceptance of the Yishuv as a whole.

Theoretically, the same could have been true for the Arab community. Arabs, similarly striving for independent statehood, which they believed they had reason to expect, similarly could have used health as an issue to demonstrate indigenous governmental competence. However, for Palestinian Arabs, the situation was more complicated. Cooperation with British and League bodies in health matters could offer a means of demonstrating national capabilities, but it also implied the acceptance of the mandatory system—and as such the acceptance of the principle, that foreign powers had the right to grant or deny statehood and to generally decide on the fate of the Arab community. Thus, cooperating with official bodies on health, i.e. other than at a grass-root level, carried an ambiguous message, both of asserting independence and of accepting subservience. For the most part, the Arab community responded to this dilemma with mostly unofficial, sometimes half-hearted co-operation with British mandate authorities, while Arab contacts with the League authorities remained almost non-existent. In addition, Arab groups in post-WW I Palestine were not in a very competitive position. Relatively to the Jewish community, they lacked general education, a dedicated, united elite, recognition in British administrative circles and foreign resources (20). There was no Arab equivalent to an independent Jewish healthcare system.

For the British government, providing healthcare services in tumultuous interwar Palestine could not have been an easy task even with the best of intentions. They faced a population made up of several, separated societies with contrasting experiences, traditions, ambitions and expectations of health, living an ambiguous status between Europe and colonial Arabia. And there was hardly any Ottoman healthcare

Gurion and Frederick Kisch. See SEGEV, Tom. *One Palestine complete*, London, Abacus 2000, pp. 153-154 (original: *Yamei kalaniot*, Keter, Jerusalem, 1999).

(20) FLORES, Alexander. Die Entwicklung der Palästinensischen Nationalbewegung bis 1948. In: Mejcher, note 17, p. 96; SMITH, note 3, pp. 80-82.

structure to build on. The Palestine Royal Commission Report of 1937 put forth a damning indictment of the conditions British troops found when they entered the country:

«The Turkish Government had done nothing in the way of advancement in modern methods of hygiene; sanitation was practically non-existent except to some extent in the larger towns; and the bulk of the Arab population, besides being ignorant and uneducated in matters of health, were fatalistic in their attitude towards disease» (21).

This complaint voices a frequent lament, and indeed the lack of Turkish health infrastructure is confirmed elsewhere (22). So, the mandate Health Department began establishing a system from scratch. While the scope of their work remained limited due to their focus on the well-being of British soldiers, they did organise hospitals, dispensaries and mobile units serving remote areas and nomadic groups, as well as laboratory services for bacteriological analyses and vaccinations. Between 1922 and 1936, four to five per cent of total government expenditures were spent on health. Meanwhile, the Jewish community turned to foreign Jewish organisations and organised their own, Jewish, health system. The two major institutions were Hadassah (the American Women's Zionist organization) and Kupat Holim (the General Sick Fund of the Federation of Labor). Hadassah was founded by Henrietta Szold, a resolute Zionist and reform activist from Baltimore, Maryland. Using funds she raised in the United States, she and her co-workers established a network of hospitals, clinics in smaller settlements and infant welfare centers. By the late 1920s, Hadassah was one of the largest employers in Palestine (23). Meanwhile, Kupat Holim, established in 1911, offered comprehensive health ser-

(21) PALESTINE Royal Commission Report, London, July 1937, p. 311.

(22) See SHVARTS, note 3, pp. 7-9; SHEPHERD, note 2, pp. 127 and 131-132; REISS, Nira. British public health policy in Palestine, 1918-1947. In: Manfred Waserman; Samuel S. Kottak (eds.), *Health and disease in the holy land*, Lampeter, Edwin Mellen Press, 1996, p. 301.

(23) SOCHEN, June. Both the Dove and the Serpent: Hadassah's Work in 1920s Palestine. *Judaism*, 2003, 52, 71-83 (72); REISS, note 22, pp. 302-304.

vices for members of the General Federation of Labor (24). Between them, they offered an extensive health infrastructure. This dynamic initiative, so unlike other colonial settings, may have surprised the British, but was for the most part welcomed. After all, these activities benefited the mandate saving British effort and expense. Indeed, Jewish funding for health services was almost double the amount of British expenditures (25).

The provision with healthcare was complicated by the substantial increase in population, which resulted in ever insufficient healthcare facilities (26). Access of the population to governments hospitals was curtailed anyway by the fact that they were primarily designed for governments officers and their dependents (27). Therefore, it was probably for reasons of convenience as much as principle that the Mandate Government decided to concentrate on public health, sanitation and disease prevention and, for curative services, «to rely as far as possible on private and municipal hospitals and dispensaries to furnish general medical relief for the population». Government funds remained limited to hospitals for special diseases or in isolated settings (28). Throughout the interwar period, an impressive number of American, British, French, German, Italian or (Jewish-)Palestinian voluntary and charitable institutions operated hospitals and dispensaries. Typically they were sponsored by Jewish or Christian parent institutions, motivated by a special affinity to the Jewish homeland or the Holy Land, respectively, and by European efforts to gain local influence via humanitarian outposts. Both groups viewed their activities as a contribution to their respective position of strength in the area and observed the other with distrust (29). There were no Moslem institutions.

(24) See SHVARTS, note 3, *passim*; SOCHEN, note 23, p. 73.

(25) PALESTINE Royal Commission Report, 1937, p. 313.

(26) REPORT, 1934, note, 4, pp 142, 149.

(27) SHEPHERD, note 2, p. 143.

(28) Quote: REPORT, 1928, note 4, p. 56; *cf.* REPORT, 1930, note 4, p. 136.

(29) SCHWAKE, Norbert. Hospitals and European colonial policies in the 19th and early 20th centuries. *In*: WASERMAN; KOTTEK (eds.), note 22, pp. 231-262; see

Sponsorship for a hospital did not create legal restrictions for patient admissions. Officially, all institutions were open to all inhabitants of Palestine, regardless of ethnic and religious background. Jewish institutions, in particular, sought to use health as a medium to embrace all societal groups. Thus, the philosophy of Hadassah entailed a mission to unite the peoples of Palestine. While this aim was primarily directed at the diverse Jewish community, it explicitly included the Arab population. In fact, Hadassah institutions not only were open to Arab patients but actively tried to reach out to them, specifically to Arab women and their children. Hadassah personnel tried to train Arab nurses, and publicized its work for the Arab community in its newsletter (30). These activities appear to have had some success in the 1920s. The 1937 British Royal Commission Report notes that patient attendance was relatively mixed in the early years of the mandate (31).

This phenomenon is worth pointing out, but evidently it was limited and short-lived. The hostilities of 1929 ended the potential for health services as a unifying force. Hospital attendance lists reveal that by the 1930s, hospitals were ruled by habits approaching voluntary apartheid (32). Obviously, all groups sought out institutions that catered specifically to them and only few people strayed into «wrong» hospitals. Particularly Jewish institutions had only very few, if any, Arab patients. In 1935, in spite of all its attempts to the contrary, the Hadassah Jerusalem hospital treated 4,923 Jewish patients but only 5 Moslems and 3 Christians, i.e. 8 Arab patients. Similarly, the Kupat Holim hospital in Motza treated 1, 757 Jewish patients and no Arabs at all. Meanwhile, the hospital of the Edinburgh Medical Mission Society treated 1,286 Moslems and 153 Christians patient, but merely 2

SCHÖLCH, Alexander. Europa und Palästina 1838-1917. In: MEJCHER (ed.), note 17, pp. 13-47.

(30) SOCHEN, note 23, pp. 73, 75, 77. SHEPHERD, note 2, pp. 128-129.

(31) Palestine Royal Commission Report, 1937, pp. 131-134.

(32) With the notable exception of British Church Missionary Society in Jaffa and Gaza, all health centres registered their patients by religion. Apparently, the significance of religious affiliation appeared so self-evident that it was almost universally listed as pertinent patient information.

Jewish patients. Generally, Jewish institutions, though officially open to all, served almost exclusively the Jewish community, while Christian institutions, which faced a far smaller target population, were more likely to welcome a more diverse clientele (33). (See Fig. 3).

What may have caused this virtual patient segregation? Settlement patterns doubtlessly were influential, since charitable institutions placed hospitals in or close to their congregational communities (34). However, geography reflected more fundamental divides. Including «other» patients was an explicit but, at best, a marginal objective. Hadassah and other Jewish health institutions clearly saw themselves as part of the Zionist movement, and therefore, in the final analysis, their aims were incompatible with Arab interests. It may have been possible to gloss over this fact to some extent during the 1920s, while inter-ethnic hostility was on a low level. After the bloodshed of 1929, this was no longer possible. Hadassah turned infant welfare stations into first aid stations and shelters for Jewish refugees. Hadassah members were urged to spread the Zionist message and intensify their efforts to raise funds for the development of Palestine. They also treated some wounded Arabs handed to them by British authorities (35). To Hadassah, all these actions were parts of the overwhelming determination to safeguard the Yishuv. To the Arab community, Jewish health work, in as much as it served Zionist objectives, became acts of aggression. It is indicative of the extent to which the societies lived in different realities, that Hadassah accompanied its activities with a naïve insistence to “be friends” with the Arabs (36). But health no longer united but divided.

Hostilities underscored the separation between parallel health care systems. Between 1931 and 1938, British health reports listed the attendance of private and public healthcare institutions, both of

(33) For instance, the hospital of the United Free Church of Scotland in Tiberias had 711 Moslem, 97 Christian and after all 223 Jewish patients in the course of 1935. Similar data for all hospitals are repeated in other Reports.

(34) SHEPHERD, note 2, p. 129.

(35) LEVINE, Marlin. *It takes a dream. The story of Hadassah*, Jerusalem, Gefen, 1997, p. 141.

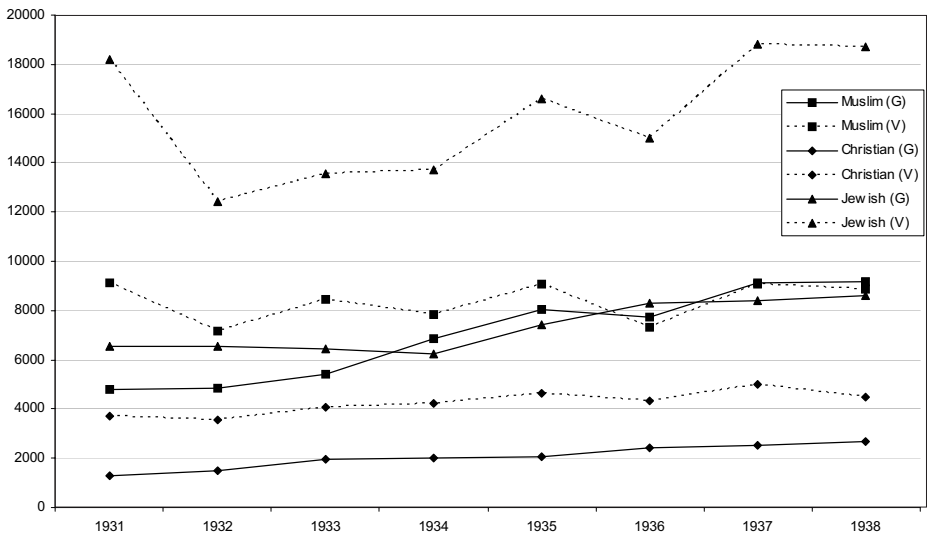
(36) SOCHEN, note 23, pp. 79-81.

Figure 3.—Patient admissions in Voluntary Hospitals 1935

(B) VOLUNTARY GENERAL HOSPITALS—1935.									
Hospital Organization.	Nationality.	Location.	Nominal Bed Strength.	Admissions.					Deaths.
				Moslems.	Christians.	Jews.	Unclassified and Other Religi. ns.	Total.	
Hadassah Women's Zionist Organization of America ...	American	Jerusalem	188	5	3	4,923	—	4,931	27
Church "Missionary Society" ...	British ...	Safad ...	58	8	3	229	—	240	1
" " " " ...	"	Jaffa ...	58	—	—	—	1,072	1,072	1
" " " " ...	"	Gaza ...	60	—	—	—	1,419	1,419	1
" " " " ...	"	Nablus ...	45	868	72	—	—	940	—
Church Mission to Jews ...	"	Jerusalem	70	22	84	1,531	—	1,637	—
Jerusalem and East Mission ...	"	Hebron ...	32	611	1	1	—	613	—
Edinburgh Medical Mission Society	"	Nazareth	70	1,286	153	2	1	1,442	—
United Free Church of Scotland ...	"	Tiberias...	60	711	97	223	3	1,034	—
Mizgab Ladach (Private donations, local and external) ...	Palestinian	Jerusalem	34	1	—	272	—	273	—
New Bicur Cholim (local funds and abroad, mostly United Kingdom and U.S.A.) ...	"	"	120	—	—	1,505	—	1,505	—
Old Bicur Cholim (local funds and abroad, mostly United Kingdom and U.S.A.) ...	"	"	20	—	—	23	—	23	—
Sick Fund of General Federation of Jewish Labour in Palestine ...	"	Motza ...	84	—	—	1,757	—	1,757	—
Rural "Sick Benefit Fund" (Kupat Cholim Amamit)...	"	Afula ...	72	1	—	1,905	—	1,906	—
Jewish Community of Haifa ...	"	Tiberias...	26	1	—	600	—	601	—
	"	Haifa ...	58	4	8	1,473	—	1,485	—
French Hospital ...	French ...	Jerusalem	150	750	692	15	—	1,457	—
" " " " ...	"	Bethlehem	80	243	520	4	—	767	—
" " " " ...	"	Jaffa ...	90	1,404	346	114	—	1,864	—
" " " " ...	"	Nazareth	56	492	343	1	—	836	—
Shaare Zedeck: Tutors and Protectors of the Jewish Community in the Holy Land (Amsterdam) ...	German...	Jerusalem	53	7	6	1,230	—	1,243	—
Rheinisch Westphalischer Diakonessen Verein Der Kaiserwerth am Rhein ...	"	"	80	1,475	1,043	47	—	2,565	—
Temple Society ...	"	Jaffa ...	20	44	153	4	1	202	—
Order of Sisters of St. Charles ...	"	Haifa ...	40	465	326	572	8	1,371	—
Associazione Nazionale Italiana ...	Italian ...	Jerusalem	60	400	548	13	1	962	—
Associazione Nazionale de Torino...	"	Haifa ...	50	251	231	140	9	631	—
Totals ...	—	—	1,734	9,049	4,629	16,584	2,514	32,776	—

in- and out-patients, according to religion. Thus, these data refer to a period when both governmental and voluntary hospitals were affected by the World Depression, which forced them to reduce bed capacity, charge higher fees or close down all together (37). As a result, the provision with hospitals was considered inadequate in some areas (38). But evidently, the reductions functioned on different levels and influenced the three communities in different ways. The absolute hospital attendance of Moslems, Christians and Jews in both government (G) and voluntary (V) institutions over time (Fig. 4) indicates that in spite of the economic difficulties attendance was maintained or even slightly increased for most groups. In comparison, the use of Jewish voluntary hospitals declined sharply after 1931 but recovered

Figure 4.—In-Patients in absolute numbers

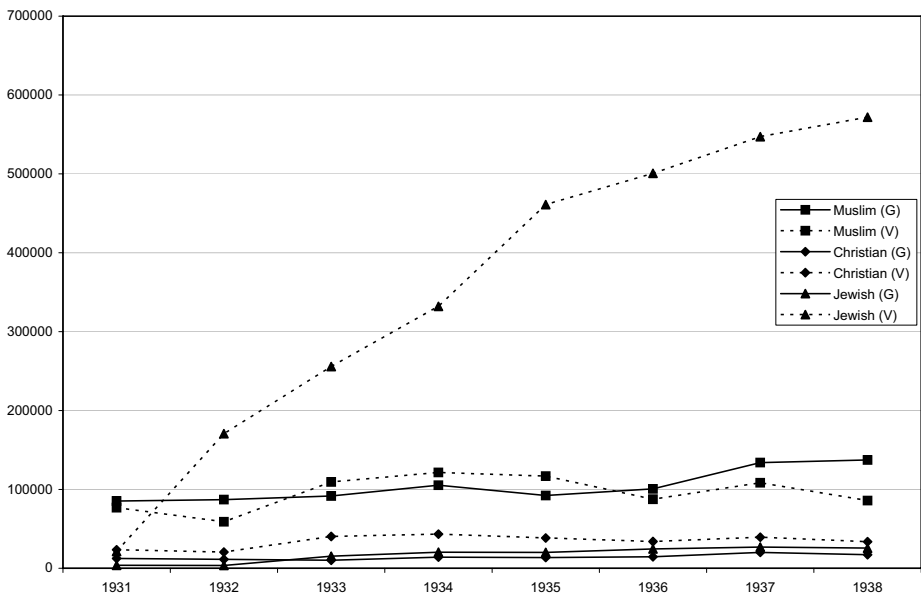


(37) REPORT, 1929, note 4, p. 86; REPORT, 1931, note 4, p. 104.

(38) REPORT, 1930, note 4, pp. 137-138.

red in the following years, especially after 1936, so that attendance in 1937 was roughly back to the numbers of the beginning of the decade. In all years, most hospital patients by far were Jewish and attended private hospitals. The smallest patient group came from Christian Arabs, the demographically smallest group. The picture is complemented by the numbers of out-patients. (Fig. 5). While there was some movement in the out-patient attendance of all groups, most developments are absolutely dwarfed by the spectacular twenty-fold increase of Jewish patients in voluntary dispensaries from just over 21,000 to over 570,000. This rise must be seen as the most stunning development in healthcare institutions in Palestine of the 1930s. It seems that voluntary hospitals compensated for their initial decrease in in-patient treatment by a strengthening of their out-patient program. But the increase in dispensary activity clearly went beyond mere substitution to gain a significance of its own. Both effects are even more obvious when the absolute numbers are related to population

Figure 5.—Out-Patients in absolute numbers

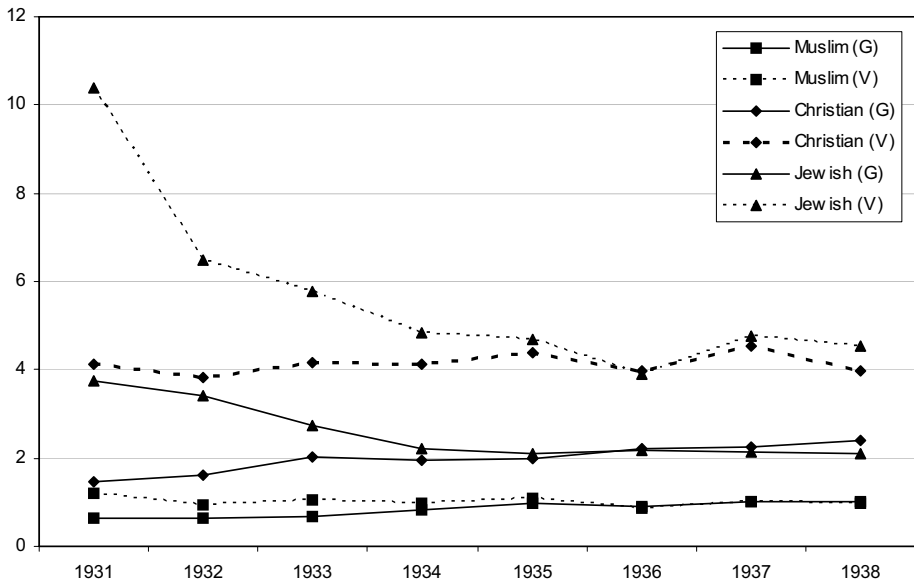


strengths(39). Tracing the percentages of in- and out-patient attendances of the Moslem, Christian and Jewish communities, results in Figs. 6 and 7. Adding percentages of in- and out-patient attendances results in Figs. 8 and 9.

Together, these figures allow several conclusions:

First, there was a clear hierarchy in the use of healthcare institution. Jews and Christians were about three times more likely to attend hospitals as in-patients than Moslems: while only two per cent

Figure 6.—In-Patients in percentage of population groups.



(39) For the calculations for this paper, estimates based on data of the ESCO Foundation, for the population of Palestine 1922-42 have been used. See: WOLF, Aaron T. *Hydropolitics along the Jordan river*, New York, United Nations UP, 1995, as available on-line: <<http://www.unu.edu/unupress/unupbooks/80859e/80859E05.htm>>.

Figure 7.—Out-Patients in percentages of population groups.

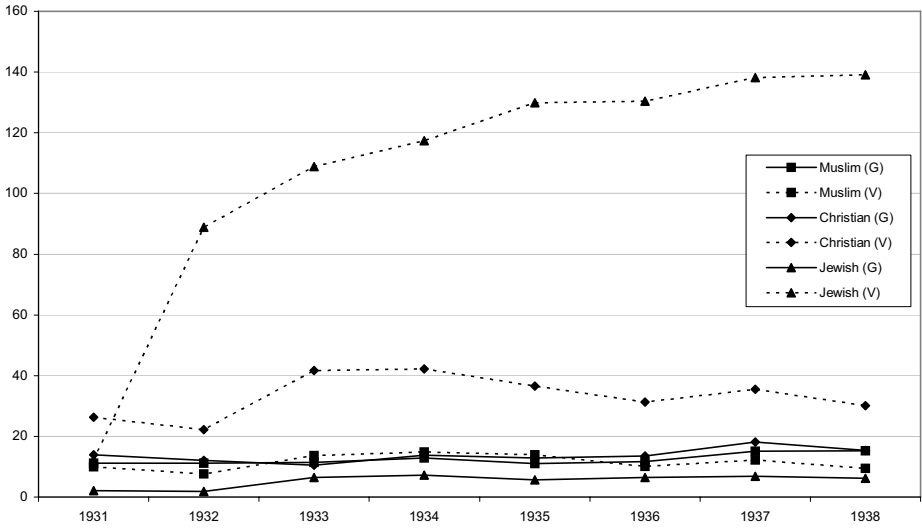


Figure 8.—All In-Patients in percentages of population groups.

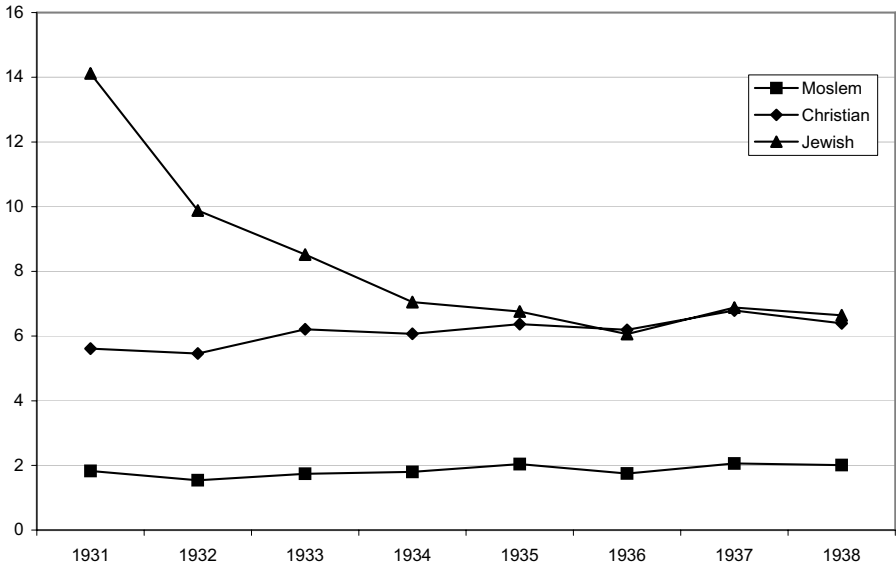
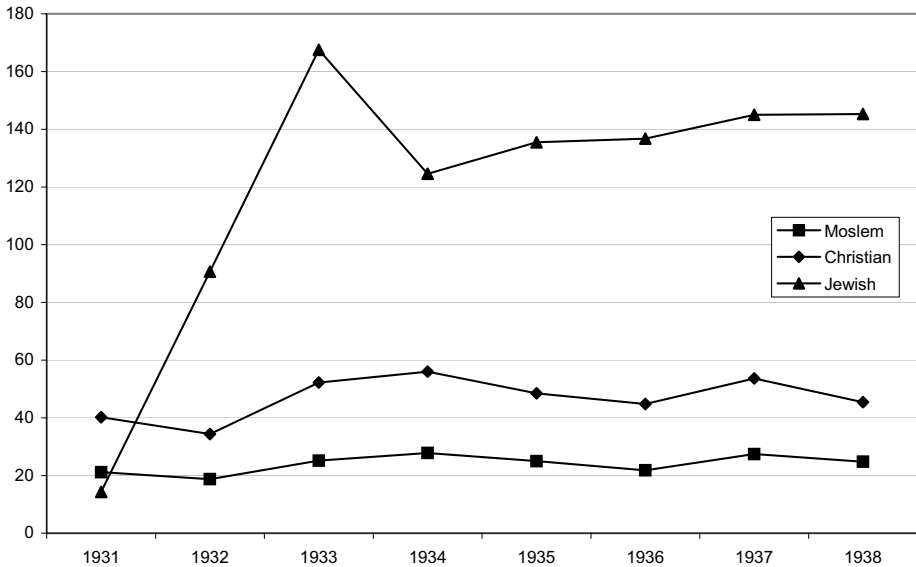


Figure 9.—All Out-Patients in percentages of population groups.



of Moslems per year stayed at hospitals, on average six per cent of both Christians and Jews did so. The discrepancy is even more pronounced in out-patient attendance. Jews were seven times as likely to use out-patient facilities as Moslem Arabs.

Second, inherent in these numbers but worth pointing out is the fact that Moslems and Christians, while both Arabs, were in quite different healthcare situations. Christians used in-patient hospital services three times as often as Moslems and out-patient services twice as often.

Third, the significance of private services for the Palestinian public health system in general can hardly be over-estimated. Almost twice as many patients were treated in voluntary as in public hospitals, and almost four times as many in private dispensaries. Thus, the significance of the voluntary institutions for the health service in interwar Palestine was enormous.

Fourth, private hospitals increased health inequalities. All groups, including Moslem Arabs, benefited from voluntary institutions. Indeed, their availability doubled the number of Moslems receiving hospital care, so that, the Moslem community profited from their proximity to two communities that drew foreign investment into the local healthcare system. But by the same token, this private investment also underprivileged the Moslem community, because they benefited relatively less than Jews and Christians, who used private institutions to a much larger extent. A comparison of the ratio of the attendance of government to privately funded institutions provides telling results for 1936 (Table 2): while roughly the same number of Moslems used state-run and voluntary institutions both as in- and outpatients, Arab Christians were twice as likely to turn to private institutions and Jews were twenty times as likely to use a private as a state dispensary. These differences clearly reflected the differences of offers open to them. As mentioned, various voluntary organisation sponsored Christian and Jewish institutions which would primarily attract their specific groups. The Moslem community, lacking a specific Moslem offer and finding it difficult to accept a private Jewish institutions, would automatically make relatively more use of public services.

TABLE 2
Ratio of usage of Government to voluntary institutions 1936 (rounded)

	<i>Moslems</i>	<i>Christians</i>	<i>Jews</i>	<i>Average</i>
Hospitals	1	0,5	0,45	0,57
Dispensaries	1,24	0,51	0,05	0,26

Fifth, differences in hospital attendances also appeared to reflect different healthcare concepts. While all groups used out-patient more frequently than in-patient services, the Jewish community did so to an extent way beyond that of the other groups. As noted above, out-patient attendance increased sharply as in-patient attendance decreased during the first years of the 1930s. By 1935, average yearly dispensary attendance for Jews was 140%, when it was only 40-50% of Christians and 20% of Moslems. In practical terms, this meant that

of ten average Moslem, Christian and Jewish inhabitants of Palestine, two of the Moslems and five of the Christians would visit a dispensary once during the year, so would all of the Jews and half of them would come back a second time later during the year. This difference had a quantitative as well as a qualitative component. In contrast to the Arab experience, the out-patient clinic or dispensary became the corner-stone of Jewish public health-care. Typically, out-patient services concern the less acute diseases, and preventive services, particularly infant and maternal welfare. More than 100% attendance suggests that the dispensary had assumed the function of a health center as it was being promoted in the social medical field as focal point of public health and welfare(40). Part of the reasons may be financial, the depression having provoked a shift of foreign support from expensive hospitals to less costly dispensaries. But such a shift inevitably had conceptual repercussions. Schemes of social medicine stressed prevention by influencing living conditions and life-styles, aiming not at curing disease but at preserving health both as an individual and common good. These ideas were in tune with contemporary ideas of improving society at large, which certainly resonated with Second Aliya immigrants, and also with Zionist schemes of creating a new state and people(41). Arab ideas may simply have lacked a similarly determined medical and political agenda.

(40) See MURARD, Lion. Health policy between the international and local: Jacques Parisot in Nancy and Geneva. In: Iris Borowy; Wolf D. Gruner (eds.), *Facing illness in troubled times. Health in Europe in the interwar years*, Berlin, Peter Lang Verlag, 2005, pp. 207-247.

(41) DAVIDOVITCH, Nadav; SHVARTS, Shifra. Health and Zionist ideology: Medical selection of Jewish European immigrants to Palestine. In: BOROWY; GRUNER, note 40, pp. 411-426; FIELD, Mark G. Soviet medicine. In: Roger Cooter; John Pickstone (eds.), *Companion to medicine in the twentieth century*, London, Routledge, 2003, pp 51-66; LAWRENCE, Christopher; WEISZ, George (eds.). *Greater than the parts. Holism in biomedicine, 1920-1950*; Oxford, University Press, 1998; MURARD, Lion; ZYLBERMAN, Patrick. French social medicine on the international public health map in the 1930s. In: Esteban Rodríguez Ocaña (ed.), *The politics of the healthy life*, Sheffield, EAHMH, 2002, pp. 197-218; JONES, Greta. *Social hygiene in twentieth century Britain*, London, Croom Helm, 1986.

This difference parallels the blatant discrepancy between Jewish and Arab child welfare. In 1927, of 28 child welfare centres, seventeen were Jewish, seven governmental or municipal and four run by voluntary institutions (presumably Christian) for Arab children(42). By 1933, 27 child health centres catered to the needs of the Jewish community (22 operated by Hadassah, five by other voluntary institutions), while Arab institutionalised child welfare was still minimal(43). In 1935, 65% of Jewish infants were under the care of infant welfare services, but only an estimated 4% of Arab infants, which certainly accounts, at least in part, for the differences in infant mortality rates (see. Fig. 2)(44). British health authorities were aware of the urgent need for more health care for Arab infants but found it difficult to obtain trained Arab staff(45). A training program specifically for midwives was partly successful, but suffered from a shortage of funding(46).

Sixth, the unequal usage of healthcare facilities meant, that medical service to the Moslem community would primarily fall within the British sphere of influence. A disproportionate percentage of the majority population group, used British services., so that the British health authorities paid primarily for the medical treatment for the Moslem Palestinians. The resulting discrepancies inevitably caused tension.

Both the British-Jewish and the British-Arab relationships in the health field were ambivalent(47).

British authorities welcomed Jewish public health activities, as long as they worked in their favour, i.e. they reduced British expenditures or improved public health without any extra costs. Official British reports acknowledged that «side by side with the government Department of Health, there grew up in Palestine the Jewish Medical Service» whose «great amount of valuable work» was credited(48). The

(42) REPORT, 1927, note 4, p. 42.

(43) REPORT, 1933, note 4, p. 143.

(44) SHEPHERD, note 2, p. 141.

(45) REPORT, 1934, note 4, p. 147; REPORT, 1935, note 4, p. 161.

(46) SHEPHERD, note 2, p. 142.

(47) REISS, note 22, pp. 310-313.

(48) PALESTINE Royal Commisison Report, 1937, note 4, p. 311.

Hadassah and Kupat Holim, in particular, were appreciated for «much useful service» (49). The British were hardly amused, however, when such activities resulted in demands for more attention and money for the Yishuv. Jewish groups complained that British authorities invested too little money in the health system in general and far too little in health care for the Jewish community in particular, the latter being largely limited to «moral support» (50). British decision makers considered their expenditures sufficient and refused to consider health services, directed specifically at one ethnic group, explaining that this would be a «violation of the principle of common citizenship between Jew and Arab» (51). Thus, British and Jewish views diverged on two issues:

«1.—the appropriate level of public health care, which, in turn, depended on diverging views on the status of Palestine and the responsibilities of governments for the social well-being of the citizens;

2.—the relative position of the Jewish and the Arab communities».

British politicians viewed Palestine as a colony-like structure and a poor country whose inhabitants paid only a fraction of the taxes of average Englishmen. Thus, they felt that Jewish inhabitants of Palestine could not expect the same level of healthcare found in Europe (52). They also believed in liberalism with only a limited government role in social issues, both at home and in their empire (53). The Jewish point of reference, however, was the best possible organized community rather than a colony, and the pronounced Socialist leanings of

(49) REPORT, 1925, note 4, p. 30.

(50) SHVARTS, note 3, p. 78.

(51) PALESTINE Royal Commission Report, 1938, p. 317. Jewish complaints were primarily voiced by the Kupat Holim, and the Va'ad Leumi, the General Council of the Jewish Community of Palestine.

(52) See OWEN, Roger. Introduction. In: *Studies in the economic and social history of Palestine in the nineteenth and twentieth Centuries*, Oxford, Macmillan, 1982, p. 4.

(53) For a discussion of different interwar conceptualisations of health, see MAZOWER, Mark, *Dark continent: Europe's twentieth century*, London, Penguin, 1998, chapter 3.

the influential Second *Aliyah* pre-supposed a socially active state (54). From a Jewish point of view, the self-organised health services deserved being rewarded by further government assistance instead of being punished by less support. And while generally Jewish agencies were not much interested in the situation of the Arab community, if there needed to be a comparison, Jews contributed more tax money than Arabs and could therefore also expect more services. This idea was incompatible with the British view, that the government needed to provide adequate health services and sanitation infrastructure to all groups of the population. Exaggerated expectations or self-induced higher service needs due to intensive colonization activities in malaria-prone areas or to the establishment of elaborate health schemes could not entail an obligation for the British tax-payer to shoulder the resulting costs. Indeed, as British observers recognized, their problem was one of «providing health services in one state for two distinct communities with two very distinct standards of living» (55).

While the British were faithful to their perceived reality, Jewish demands were similarly in tune with theirs. Consistent Jewish immigration ensured the influx of medically trained personnel. Soon, the ratio of medics per population reached and sometimes passed European proportions so that, by 1936, legislation was introduced to prevent «overcrowding» of the medical profession (56). Nevertheless, in 1938, British reports noted one doctor for 670 people, one dentist for 2000 people and one pharmacist for 3200 people (57). But this was arithmetic theory. The doctors were overwhelmingly (German-Jewish), and they resulted in a patient-doctor ratio within the Jewish community of 1:300, the lowest in the world (58). Meanwhile, the British concept of an appropriate colonial doctor-patient ratio was closer

(54) SHVARTS, Shifra. Kupat Holim and Jewish health services during the mandate. In: WASERMAN; KOTTEK, note 22, p. 334; TESSLER, note 1, pp. 61-68.

(55) PALESTINE, 1937, note, 48, p. 317.

(56) REPORT, 1936, note 4, p. 176.

(57) REPORT, 1938, note 4, p. 170.

(58) SHEPHERD, note 2, p. 130.

to 1:4000 (59). Such ideas were out of touch with Jewish-Palestinian realities and belied myths of a «civilizing mission» (60). But the British position was indeed difficult. Financial assistance of European-style health schemes would not only grant to the Jewish community more than their perceived fair share in relation to their Arab neighbours. It was tantamount to subsidising a process of increasing autonomy which went against the interests of the British Empire. But so did renouncing the enormous contributions of the Jewish Health System and private Christian charities to health care in Palestine in general, those contributions that so conveniently relieved British authorities from duties and expenses. The British Government tried to have it both ways, to benefit from the input of private achievements, and still retain public control – and failed. By welcoming the degree in which Jewish health organisations supported and relieved the British Health Department, and by allowing the Jewish Health Service to become a more important supplier of health provisions than the Government Health Department, the British Government delegated state responsibilities and effectively gave up a good part of its claim for governance. The British had criticized the Ottoman Empire for not providing health care for its citizens, implying that this deficiency reduced Ottoman entitlement to the area. Twenty years later, the British themselves, without apparently being aware of it, laid themselves open to the same argument.

The British-Arab relationship in health work was much less noticeable but no less difficult. In fact, Arabs hardly appeared as players, and if they did, as in their contribution of anti-malaria drainage work, their image was to work «voluntarily (...) under the Department's advice and with its assistance» (61). Lacking outside help, funding and know-how as well as an elite with a clear plan of a gaining sovereignty, it seems most Arab citizens limited their efforts to either cooperating in schemes of the British Health Department or working in informal health support not visible to Western observers and not conducive to

(59) SHVARTS, note 3, p. 81.

(60) See WORBOYS, Michael. Colonial Medicine. In: COOTER; PICKSTONE (eds.), note 41, pp. 67-80.

(61) PALESTINE, note 48, p. 314.

state-building. From a British point of view, Arab participation in health work was limited but undemanding. This relaxed state ended towards the end of the mandate period with increasing Arab protests against Jewish immigration and mandate regulations. The Arab uprising after 1936, in particular, tangibly interfered with organised health work. Arab Public health workers, such as sanitary inspectors etc., inevitably acted in British employment and were therefore regarded as part of the mandate administration and became targets of attacks (62). In addition, British reports complained that regular attendance of health institutions and generally travel in the area was severely hindered by violence (63). Thus, health administration was one field in which the increasing alienation between British and Arabs were played out. In this context, the Jewish medical institutions, theoretically open to the entire population, contrasted positively with the Arab attitude and made the latter appear like ingratitude (64).

3. CONCLUSIONS

Interwar health work in Palestine formed an integral part of the complicated struggle for power and control. Health work in interwar Palestine systematically disadvantaged the Arab, particularly the Muslim Arab, population. This finding is not surprising or unusual in the sense that the economically or socially disadvantaged part of society commonly receives the lesser share of health care (65). In interwar Palestine, this inequality reflected and contributed to a conflict which haunted the entire twentieth century and continues to do so in the twenty-first.

The impact existed in several layers. On a practical level, the different health status of the ethnic groups tangibly influenced warfare. Thus, Jewish troops may have defeated Arab troops during 1948-49

(62) REPORT, 1938, note 4, p. 168.

(63) REPORT, 1938, note 4, p. 165.

(64) PALESTINE, 1937, note 48, p. 312.

(65) See PURDY, Michael; BANKS, David (eds.). *Health and exclusion*, London, Routledge, 1999.

not only because they were better equipped, better organized, more motivated and enjoyed strategic advantages over their disunited, disorganized and often half-hearted enemies, but also because they were, on average, healthier, could rely on a better health network when in need, and could literally see better.

The question of the health network must have been significant, taking into account the extent to which Arabs relied on the health system of the government that was disappearing as fighting broke out. While there were important private health institutions, these were directed primarily at the minority Christian part of the population. The Moslem community, i.e. ca. 86-88% of all Palestinian Arabs of the time, never established a health system of their own. This omission reflected the general unbalanced state of institutional organization, and one may, indeed, blame the Moslem elite for this failure. For a fair view, however, the different position within a mandate structure and, above all, the different degree of foreign support must be taken into account. There were no foreign-funded Moslem hospitals in Palestine because at that time there were no foreign Moslem powers, willing and capable of funding them. Meanwhile, the Jewish community had established not only isolated hospitals but quasi governmental health administration structures, ready for use at the moment of independence.

Besides, health may have been an influential psychological factor, difficult to define and impossible to quantify. Yet, contrasting experiences of the controllability of health may have been one piece in the total picture of contrasting controllability of life and fate, including political fate, certainly a crucial factor determining morale.

Finally, issues of health and health administration as signs of governmental competence had important political repercussions. British health work might have been credited with similar achievements in other, more clearly colonial, settings. But in Palestine, it was seriously hampered by the limited vision of the status of the area. Meanwhile, common images of both the Jewish and the Arab population were in harmony with the general view of the respective ethnic group and thus served to further strengthen ethnic stereotypes: While the Jewish community appeared as active, competent, independent, successful, its

Arab counterpart came across as largely passive, subservient to and sometimes obstructive of British public health efforts. Thus Jewish institutions gained a reputation as a competent, stabilizing force, which increased the credibility of Yishuv.

Summing up, of all groups that formed part of interwar Palestine, the Jewish community was plainly most determined, competent and active in providing systematic and institutionalized health care, but also the most privileged in enjoying outside support. These facts were indicative of the situation at large. By the time the interwar period had given way to the postwar world, the Jewish community ruled the area.