**Donors and Recipients:**

**Hadassah, the American Jewish Joint Distribution Committee, and the “Medical Service for *Olim*” between 1944 and 1953**

**Introduction**

In recent years, notably today, with millions of refugees fleeing Ukraine, there has been growing interest in the issues of immigration, the movement of people between countries, and medical access for exiled refugees. Wars invariably lead to large waves of immigration as well as to fears of epidemics, diseases, and humanitarian disasters. In the previous century, World War II and the catastrophe of the Holocaust led to the migration of millions of refugees and displaced persons across countries and continents. After the war, Jews from all over the world began immigrating to Israel, including refugees, displaced persons, and many sick and disabled people. This period, referred to as the post-war mass immigration, was characterized by Jews’ ideological aspirations for a homeland together with their practical need for a place to settle and to realize their personal dreams. Not only Jews wanting to immigrate to Israel and make it their home and create a national center there felt the strong bond of the Jewish people to the Land of Israel; Jews in the Diaspora also wanted to help in this endeavor. This drive to help, having intensified after the Holocaust, was expressed in various ways, particularly through economic and humanitarian aid. Prominent in this context is the story of two American Jewish humanitarian organizations, Hadassah and the American Jewish Joint Distribution Committee (JDC), which were established as aid and rescue organizations and soon became service and care providers. While the work of these organizations has been researched and documented in numerous books and articles, this is the first study of how the mission of Hadassah and the JDC was implemented through the government’s “Medical Service for *Oli*m in the Land of Israel” (SHAREL).

This article seeks to apply an historical approach to document the policies of Hadassah and the JDC on matters regarding the *olim* and to show how they mobilized their resources to help provide medical services for *olim* in the years 1944–1953. Unlike most Jewish organizations active at the time, Hadassah and the JDC did not restrict their contribution to assistance and support from overseas, but actually became direct service providers. Their contribution to the Israeli health system, society, and establishment remains evident to this day.

In this article, I make two main arguments. First, the fact that Hadassah and the JDC managed key parts of the health services in the Land of Israel had an impact on the state’s attitudes and even capabilities regarding the medical aspects of *olim’s* absorption. Second, reliance on these American organizations to provide care for specific segments of the *olim* population, such as the sick, the elderly, and the disabled, has influenced Israel’s health policies and the nature of its health system in ways that are felt to this day. For example, the National Health Insurance Law enacted in 1994 did not include services such as geriatrics, psychiatry, and rehabilitation in the health basket detailed in its Second Appendix. That these services were provided by the American organizations during this period under study can explain why they were omitted from the law.

Scholars addressing the relationship between American Jewry and the Land of Israel emphasize the connection between American Jewry and the Israeli leadership regarding *aliyah* and the Americans’ contribution and philanthropic involvement. At the beginning of the last century, the relationship between Jews in the Land of Israel and American Jewry differed from Israel’s relationship with other Jewish communities in the Diaspora with respect to goals, scope, involvement, activity, and support. The establishment of American Jewish organizations, which were not all Zionist, was an outcome of this unique relationship.

While European Zionists, under the direction of leaders such as Chaim Weizmann and David Ben-Gurion, tended to idealize negating the Diaspora in their zeal to establish Jewish sovereignty, American Jewry certainly did not share in this negation. According to Gal, American Jewry was characterized not only by their desire to gather their scattered people in their own independent homeland but also by their struggle with anti-Semitism and assimilation in the United States.1 American Zionists, unlike many of their European counterparts, developed a positive attitude toward Jewish religion and tradition, as Gal shows in references to the Hadassah organization and its leader, Henrietta Szold, who recognized and appreciated the importance and inextricable connection of the Jewish existence in the Diaspora with the desire of Jews to immigrate to Israel.1

Lasansky notes that even before the establishment of the State of Israel, the contribution of American Jewry had been growing, its initial material contributions expanding over the years into an alliance between the United States and Israel in the international arena. American Jews’ early kernel of support was already evident during the Ottoman period and at the beginning of the British Mandate, at a time when Jews in the United States were struggling with prejudice and immigration quotas.2 Between 1938 and 1948, Jewish organizations in the United States, operating under the shadow of the Holocaust of the European Jews, promoted the vision of Zionism—the establishment of the State of Israel. This provided an extraordinary window of opportunity for these organizations to influence the character of the Jewish state. Especially outstanding were the humanitarian activities of the American military to assist Arabs and Jews living in the Land of Israel during the Ottoman period undertaken due to initiatives of American Jewry. The American Jews’ determination to assist the Yishuv led to the establishment of the JDC in 1914, one of the oldest and leading institutions of American Jewry. Other American Zionist organizations were established around the same time, including Hadassah (1912), the American branch of the Jewish National Fund (1901), and the Zionist Organization of America (1897).3 Philanthropic support from American Jewry, which was one of the sources of support for the Yishuv as well as for the establishment of the State of Israel and its nascent institutions, continues to this day.4 According to Segev,5 American Zionists, such as the Hadassah women, did not wish to be defined solely by their help in building the State of Israel. They also wanted to bring the American spirit and the American Jewish Zionist tradition to the new state, without compromising their loyalty to the American nation. Golander and Brick note that Hadassah would be remembered as a pioneering organization mainly in the areas of childcare, preventive medicine, the establishment of hospitals, and medical education. The JDC’s activities, with their focus on helping the elderly and the disabled, made a unique and significant contribution to the development of Israeli society and to shaping its social values. Another singular aspect of the JDC’s activity has been its long-term investment in weak target populations, which helped Israel during its difficult early years by relieving its state institutions from responsibility for caring for the absorption and well-being of these vulnerable populations. 6 (Golander and Brick, pages 220–221)

Although in the first years of the state’s establishment, there was little immigration from the United States to Israel, American Jewry nonetheless helped Israel absorb Jews from other countries. American Jewry used its political power to help obtain compensation from West Germany (1952) and to influence U.S.-Israeli relations. In addition, American Jewry was concerned about its own status in light of the establishment of a large, new Jewish center that attained political independence.7 Indeed, American Jewish organizations felt a responsibility toward the new state, and some believed that the State of Israel would not survive without their political and economic assistance.8

The Jewish aid organizations were not created in a vacuum. After World War I, many voluntary organizations engaged in humanitarian activity and their activities intensified during World War II. Delegations of American medical teams, supplied with dressing materials and operating room equipment, volunteered to assist the British. These teams were usually named after the institutions that established them. Hadassah’s initiative to form such a medical delegation that could operate near the battlefield was adopted by the American Zionist Medical Unit (KMTA), funded by the JDC and the political authority of the Provisional State Council in the Land of Israel.9 It is worth mentioning that during the war, two humanitarian delegations were sent (April 17, 1943, and January 8, 1944) from the Land of Israel to provide medical aid to the Soviet Union. Six ambulances, marked with a red Star of David, three mobile operating rooms, medical equipment, and socks and gloves knitted by the women of the Yishuv were sent to the Red Army base in Teheran.10

The American Red Cross inspired the establishment of Jewish aid organizations in the United States.11 Initially, the Red Cross only assisted soldiers of sovereign states (in coordination with the combatting parties).12 However, already during World War I, the Red Cross also cared for civilians, although this was not explicitly covered by law. During World War II, civilians were protected under the rules of the Convention, providing they were state nationals. The Jews in the Nazi extermination camps did not meet this criterion and were therefore not helped by the Red Cross. Despite pressure from the Jewish World Congress on the Red Cross to grant Jews access to its services, the Red Cross did not change its position.13 Services were eventually provided by the Jewish aid organizations, particularly American humanitarian Jewish organizations, led by Hadassah and the JDC.14

The mobilization of American organizations to aid the Land of Israel began during World War I, but due to the war, American citizens were not allowed to travel there. Only after the British conquest of Jerusalem in December of 1917 did the Hadassah women begin making contacts to send a medical unit to the Land of Israel.15 The idea of establishing a women’s voluntary organization was not unique to Hadassah. Associations of middle-class women engaging in voluntary and philanthropic activities had been widespread in the United States since the late 19th century (mostly working within religious-ethnic frameworks), working primarily in the areas of health, education, and welfare. These spheres of activity reflected the gender roles in the society at the time, with men seen to be operating in the business and public spheres and women presumably dedicated to the home, culture, health, and welfare. Henrietta Szold, the first Hadassah president, was a true trailblazer, becoming active in areas traditionally reserved for men,16 and her work among men in the Land of Israel was also exceptional in that sense. Gal describes the establishment of Hadassah in the context of social feminism that was developing in the United States and views it as a feminist-social-Zionist organization that aspired to create a society characterized by joyful motherhood and happy childhood.17

According to Steyer-Livni, the organizations that operated in the Land of Israel transformed the challenging and complex process of immigration into an simplified, uniform scheme of transition from Holocaust to revival, while ignoring problems and difficulties.18 However, the immigrants were sometimes regarded as a problematic group that could threaten the Zionist order. In contrast, the Jewish-American media emphasized that the survivors recovered quickly due to their inherent qualities rather than any actions of the society integrating them. American Jews had a largely positive view of the Holocaust survivors and regarded them as a heterogeneous group of people with individual rehabilitation needs.19

Studies of immigrant absorption prior to the establishment of the State of Israel, particularly in the area of health needs, have identified discrepancies between perceptions and reality. A prominent study in this area by Stoller-Liss examining models of immigrant absorption into the health system helped shape the image of public health and make it into a national mission.20 This view was also expressed in articles published by the directors of the health system before the establishment of the State. Dr. Yosef Meir, the chief physician of the largest sick fund, Clalit (Clalit Sick Fund), envisaged that healthy people would immigrate to the Land of Israel. Many other articles sharing this vision were published in the Clalit journal, *Eitanim*. The journal’s name, meaning strong and steady in Hebrew, reflects the ambition to establish a young, healthy generation in Israel (the “Sabra generation”).

The situation changed radically following the establishment of the State of Israel, with the beginning of post-war mass immigration and the arrival of thousands of sick, elderly, and disabled people. The directors of the health system understood the magnitude – and burden – of the task at hand. For example, Dr. Meir was among the first to face the new reality and accept that not only the healthy would immigrate to Israel. After visiting refugee camps of Yemenite Jews in Aden, Yemen, Dr. Meir demanded that they be brought to Israel without delay, as this was a matter of life and death. Hadassah volunteered to establish a pediatric hospital for them and provide them with medical care. Although Dr. Meir basically believed that state institutions should have been the care provider for these refugees, he decided that Hadassah would operate the health services in Rosh HaAyin, recognizing the organization’s abilities and the need to focus on helping the Yemenite *olim*.21

The issue of providing medical access for the *olim* gained special significance when discussions about the establishment of an Israeli government began. In the first session of the new government (May 20, 1948), the health and the education portfolios were not included in the list of ministries. These portfolios were not considered an integral part of the future government because, up until then, medical institutions had been directed by the Jewish National Council. Health continued to be a low-priority topic in the government discussions until a health minister, Haim-Moshe Shapira, was appointed in January 1949. However, the minister’s portfolio consisted of internal affairs, *aliyah*, and health, with health ranking only third in importance.22

In December 1948, the roles of the Ministry of Health as the inspector and provider of medical services were decided upon by the new government.23 The need to provide comprehensive health services within a short time opened the doors to Hadassah and the JDC, organizations that regarded health and welfare as top priorities and were able to bridge the growing gap between the needs of the population and the availability of these services. Temporary solutions established at that time remained in place for many years to come. For example, the JDC managed Malben (Institutions for the Care of Handicapped Immigrants) until ..., although the original contract was only until …, while Hadassah continues to provide medical services in hospitals and the community to this day.

**Historical background: Hadassah, the JDC, and the Medical Services for the *Olim***

Before the establishment of the State of Israel and during its early years, medical services were mainly provided by the Clalit Sick Fund, which was part of the Histadrut (General Organization of Workers in Israel) and had clinics and hospitals for the workers throughout the country. Following the operating principle “From each according to their ability and providing each according to their needs” left Clalit in constant deficit and lacking resources. Other sick funds operating during that time were small, and their activities were limited. Their management and ideologies were based on European *olim* who came to settle in Israel and wanted to develop medical services as part of establishing an independent state. Like these other small sick funds, Hadassah also was promoting the independence of the Yishuv through donations, training of medical personnel, and providing medical services in the central cities. Hadassah established a nursing school, built hospitals in all the large cities, drew plans for opening a medical school, and established its own Amamit Sick Fund. In addition to the organizations detailed above, medical services were also provided by the British Administration. With the establishment of the State of Israel, the Ministry of Health began developing medical services and building hospitals, primarily using the infrastructure left by the British authorities. The JDC also began operating in Israel during this period. Although, in theory, Hadassah and the JDC sought to support the residents of the State in developing their own medical services, in practice, both organizations ended up becoming service providers for many years. The organizations described below have been instrumental in establishing Israel’s health and welfare systems.

**Hadassah:** “The Women’s Zionist Organization of America” was founded in New York in 1912 as an association of American women volunteers. The organization invested most of its resources in developing health and welfare services in Israel. The story of Hadassah begins when Emma Gutheil, the founder of a women’s group called “Daughters of Zion,” accompanied her husband, Prof. Richard Gotheil (Lecturer in Semite Studies), to the Second Zionist Congress in Basel in 1898. There she met Benjamin Zeev Herzl, who encouraged her to organize American women in support of the Zionist cause. Upon returning to the United States, Gutheil invited young women to study Zionist and Jewish topics together. According to Levin, the group’s name was changed from “Daughters of Zion” to “Hadassah” in memory of Emma’s mother.24 Shchory and Shvartz describe similar women’s groups established at that time, which were named after heroines from the bible (Deborah, Rivka, etc.). Women’s organizations of this kind were common at the time, and members of Emma Gutheil’s group became leaders of the Zionist women. Henrietta Szold joined the group after encouragement from Rabbi Judah Leon Magnes.

Henrietta Szold was appointed president of Hadassah at the organization’s founding convention on March 2, 1912. Inspired by the impression the Land of Israel left on Henrietta Szold and Emma Gutheil’s sister, who had visited there, the convention decided that Hadassah would focus on public health and midwifery. This decision determined, in effect, Hadassah’s activities in Israel in the coming years.25 Other important resolutions made at the convention were setting Hadassah’s goals to spread the Zionist idea in America and to establish and develop medical-social services in the Land of Israel. 26

Hadassah played a critical role in establishing medical services in the immigrant camps between 1940 and 1948, the period between World War II and the War of Independence, when the struggle against British rule was at its peak. Hadassah’s attitude toward the British authorities was ambivalent: on the one hand, the organization expected cooperation with the British; on the other, it joined the Jewish war effort, all the while aiming to remain apolitical. Hadassah mobilized all its resources in America in the struggle to promote *aliyah*. Petitions were sent from the New York offices of Hadassah to the British ambassador in the United States and to the British government and distributed leaflets throughout America, calling for the gates of the Land of Israel to be opened for the European Jews and for allowing all those who wanted to make it their home to be allowed to do so.27 After the establishment of the State of Israel, Hadassah wanted to focus its activities in Jerusalem, whereas the government’s position was that Hadassah should maintain its hospitals and establish a medical faculty in Jerusalem.28

**The JDC:** “The American Jewish Joint Distribution Committee” was founded in 1914 with the aim of assisting the European Jews and promoting the process of their integration into their countries of residence. During the war and the following decade, the JDC was the main funding body for the *aliyah* of Jews from Europe and from Muslim countries to Israel. The activities of the JDC for Israel expanded beyond its original objectives, although it has always refrained from intervening in political matters. During the years of *aliyah*, considerable friction existed between the JDC and the Jewish institutions in Israel, although they managed to continue collaborating. In hindsight, it is clear that the aid received from the JDC was essential for bringing the sick and disabled *olim* to Israel.29 According to a study by Golander and Brick, the JDC was founded by wealthy Jewish philanthropists, some with an Orthodox religious background and others from a secular, high socio-economic background, who set up a committee to coordinate the aid efforts of American Jewry to the Jews in Europe and in the Land of Israel during War World I.30

The JDC soon developed into a multifaceted and efficient organization, capable of simultaneously managing rescue, welfare, rehabilitation, and medical care missions in various places worldwide. The JDC’s unparalleled organizational flexibility allowed it to respond quickly to distress and crisis situations by setting up soup kitchens, distributing food parcels, sending medicines and medical staff, providing professional training, giving loans to small businesses, and providing agricultural training.31 The goals of the JDC have been modified over time not through any formal policy change but as a result of its practical work. Although the JDC defined itself as an apolitical aid organization, it did adopt a pro-Zionist stance. The pro-Zionist position of the JDC is evident when considering the considerable help it provided to European Jewry, matching that of the United Israel Appeal and the Jewish National Fund. Steyer-Livni points out that, in general, the American organizations did not identify with the European “other” but rather sought to build an American Zionist identity that respected the Jewish past, religion, and culture that had existed for many centuries before the war.32 With the establishment of the State of Israel and increasing hardships, the JDC assumed the management of care for the elderly, sick, and disabled (“the disadvantaged”). At that time, the activities of the JDC in the Jewish camps in Europe and in the Arab countries ebbed gradually, with the closing of the camps and the immigration to Israel. Operating within the State of Israel was a new endeavor for the JDC and was contrary to its declared mission. Although intended for the short term, in practice, the JDC continued to operate within Israel until 1975.33

**The Medical Services for *Olim* (SHAREL)**

SHAREL, established in 1944 by the Jewish National Council and the Jewish Agency, operated from 1944 to 1953. The organization’s aim was to manage various medical aspects of *olim’s* absorption, including medical screening, entry examinations, and medical insurance. SHAREL was initially directed by a physician from Hadassah (Dr. Theodor Grushka) and became fully managed by Hadassah in 1946. After the establishment of the State of Israel, the Ministry of Health attempted to leave the management of SHAREL in the hands of Hadassah, but as Hadassah could not accept this responsibility, SHAREL management was transferred to the State in 1949.

Preparations to absorb the *olim* began before the establishment of the State of Israel. However, prior to the post-war mass *aliyah*, the Israeli Ministry of Health lacked resources and professional staff. In 1948, approximately 100,000 *olim* arrived in Israel during the height of the War of Independence. *Aliyah* peaked between May 1948 and the end of 1951, and by the end of this period, about 700,000 people had immigrated to Israel. As the population grew, health issues increased; indeed, SHAREL experienced economic hardship for most years of its operation. During this time, the demographics of the immigrant population changed. In the years following the War of Independence, more women and children and fewer young people of working age immigrated to Israel.In addition to being malnourished, the *olim* suffered from poor physical and mental health. Many *olim* could not work because of old age or chronic conditions. Among the *olim* forced to make *aliyah* from enemy countries, approximately 40% suffered from tuberculosis, skin, eye, and kidney conditions, and the children suffered from weakness and rickets caused by malnutritien.34

It became clear that a comprehensive medical system would be required to care for the *olim* throughout their journey, from their countries of origin to the places of absorption in Israel. In 1944, the Medical Development Committee of the Jewish National Council recommended the establishment of a new medical service to be managed by the health department of the Jewish National Council in collaboration with the absorption department of the Jewish Agency. They planned to establish medical stations in countries of origin where medical services were inadequate (especially in the Eastern countries). Staff in these stations would examine and triage the *olim*, provide initial medical care, treat serious diseases, isolate patients with infectious diseases, disinfect clothing, and provide information. Once in Israel, the *olim* would receive medical and nursing assistance. Olim requiring hospitalization would be transferred to hospitals and, after examination, transferred to places of permanent residence or to immigrant camps, where hospital rooms, clinics, special recovery rooms, nurseries, and kindergartens would be established. All the *olim* were to be registered with one of the sick funds. The health department of the Jewish National Council would establish a central medical service to implement this program.35 The plan was devised by Dr. Katzenelson, the director of the health department of the Jewish National Council, driven by the sense of urgency of the situation.36

Funding for the medical services was to be provided by The Jewish Agency. However, the Agency was unable to provide the funds required to ensure the health of the *olim*. The Clalit Sick Fund, which provided the actual health services for the *olim*, also ran into financial hardship and demanded that the Jewish Agency fund half of the costs of medical treatment. The deteriorating financial situation led the Clalit Sick Fund to threaten to cease providing medical care for the *olim*.37 The fear in the Jewish community was that the British would use the presence of a large number of sick people in the Yishuv as an excuse to ban immigration to Israel.38

It was these difficulties, combined with the desire to ensure mass immigration to Israel, that led to the establishment of SHAREL by the Jewish National Council. Hadassah was asked to manage the newly established service.39 Dr. Yassky, the medical director of Hadassah in the Land of Israel, was a visionary who had already anticipated the circumstances that would arise following World War II. In his presentation to the Hadassah Council, he described the three areas of medical needs: prevention, curative treatment, and medical staff education. He envisaged a significant role for Hadassah in these areas and estimated that although Hadassah would not be able to solve all the problems created by the post-war mass *aliyah*, it could put the *olim* on the right path. Furthermore, negotiations between the health department of the Jewish National Council and the British government were failing repeatedly because of mutual suspicion and political motives. In Dr. Yassky’s opinion, Jewish medical services should be financed by a dedicated, newly established fund and would be provided by different bodies performing different functions: Clalit Sick Fund—ambulatory services; Hadassah—preventive medicine; the Jewish Agency and the Jewish National Council—rehabilitation; and the government, the Clalit Sick Fund, and Hadassah—hospitalization.11

In June 1944, Dr. Yassky submitted a 12-page document with recommendations for the development of medical services after the war. The plan assumed that immigration would affect many aspects of life in the Yishuv: public health, economy, politics, agriculture, industry, construction, and others. Under the assumption that the population in Israel after the war would amount to about 600,000 people, the plan suggested the following: the expansion and organization of community services; government funding for an additional 900 hospital beds for the Jewish population, 440 beds for tuberculosis patients, and 600 beds for patients with chronic diseases; and government care for the mentally ill.

Hadassah’s plan assumed that no more than 100,000 people would immigrate to Israel each year, and therefore five years after the war, the population would reach 500,000 people. The *olim* would be in a poor mental and physical condition, requiring the development of services for preventive medicine, medical insurance, nutrition, and housing, along with increased government assistance. Hadassah planned building an additional source of funding based on donations collected in Israel and in the Diaspora. Training of medical staff would be carried out by establishing a medical faculty, expanding the nursing school, opening institutions for continuing education of medical staff, and training of technical medical staff at the Hebrew University in collaboration with Hadassah.40

With the rising public interest in questions surrounding medical care for the *olim*, the Jewish National Council established a public committee to discuss the topic. Dr. Theodor Grushka from Hadassah was appointed Medical Director and Supervisor of Health Services.41 In addition, a plan was made to provide free hospitalization for the *olim* for a period of six months in Hadassah hospital.42

Prolonged discussions ensued, and there were no significant changes to the ways in which medical services were provided to the *olim* during 1945. The small number of *olim*, and the fact that the Yishuv was preoccupied with other struggles at the time, also contributed to the delay in implementing the plan. However, the department that had been established within the Jewish National Council began operating under the directorship of Dr. Grushka. Already in its early days, the health department had asked Hadassah to consider the possibility of collaboration and funding for establishing SHAREL.

In June 1945, Dr. Eliezer Kaplan43 approached Hadassah in the Land of Israel and requested that it increase its share in funding the department. Hadassah had already provided $10,000 for nursing services in the *olim* camps and, although it wanted to participate in immigrant care, it did not wish to contribute to the overall budget of SHAREL. Then, the proposal was made for Hadassah to direct the entire department. The Hadassah officials, under the impression that the Jewish Agency would finance half the cost if Hadassah assumed directorship, asked Dr. Yassky for his opinion on the matter.45

In October 1945, a proposal was discussed to send a delegation of Hadassah women to the Land of Israel that would collaborate with the JDC and the United Nations Relief and Rehabilitation Administration (UNRRA) to prepare a joint infrastructure for the care of the 100,000 *olim* who were expected to arrive from the displaced persons camps. The idea appeared to align well with Hadassah’s vision; as Dr. Yassky pointed out in his reply, “History has changed since 1916 when Hadassah had to send doctors and nurses from the United States to the Land of Israel.”46

In the meantime, the state of SHAREL was deteriorating. The director, Dr. Grushka, did his best, but he lacked the authority, staff, and necessary budget required to develop adequate health services required to meet that would meet the needs of the hour. At the end of June 1945, Dr. Grushka wrote: “The personal status of SHAREL’s director is that of a bankrupt person who is unable to pay their debts.” On July 27, 1945, he handed in his letter of resignation but was asked to withdraw it and to wait for a meeting with members of the Jewish Agency directorship, who were due to return from London. (Eventually, this meeting was not held because of debts of the department hadn’t been paid). In September 1945, Dr. Grushka met with Eliyahu Dobkin,48 who requested that Grushka submit a proposal for continuing the activity of SHAREL, which he did. However, the situation of SHAREL continued to worsen, and in October 1945, Dr. Grushka handed in his final resignation. He may well have changed his mind had he known how close SHAREL and Hadassah were to signing an, but he was utterly worn out.50

The first draft of the agreement with Hadassah was drawn up in May 1945, and at the end of that month, the final draft was approved by all the institutions.51 A year later, a formal agreement regarding the transfer of SHAREL management to Hadassah was signed between the Jewish Agency, Hadassah, and the Jewish National Council. Dr. Yassky, the director of Hadassah, saw this decision as a test for the organization, writing:

In the current circumstances, we will soon face the necessity to absorb them [the *olim*] in a very short time indeed. These will be testing times for our movement. Our future will be weighed and measured by our success in absorbing the *olim*. The challenge of absorbing the *olim* is beyond the routine work of the medical institutions in the land and will require all the institutions to take it upon themselves to provide health services and mental rehabilitation for the *olim* and to support their adjustment to the conditions of the land.52

In May 1946, representatives of the Jewish Agency, Hadassah, the Clalit Sick Fund, and the Jewish National Council convened to discuss the problems that would dominate future deliberations: “Among the *olim* in the camps and in Europe were many disabled people, some of them partisans and fighters.”53 The JDC was recruited later to assist with this challenge. The policy formulated in the meeting was that SHAREL would make the decisions about immigration of the sick and disabled, and UNRWA and the JDC would help to bring the *olim* to the Land of Israel.54

A month later, the agreement was signed. It was applied retroactively to regulate the transfer of medical services from the Jewish National Council to Hadassah. Hadassah was to be responsible for meeting the medical needs of the *olim* and for the effective management of SHAREL.55 SHAREL, under Hadassah’s management, would not operate outside the borders of the Land of Israel, and medical examination of the *olim* overseas would be carried out by the *Aliyah* Department of the Jewish Agency. Health services would be provided to the *olim* for one year, and at the end of that year, SHAREL would have no further obligations toward them (excluding those who had been hospitalized or who were still in hospital by the end of the year). Hadassah had been authorized to collect fees from the patients and their family members in order to partially cover the costs of medical services. The amount to be paid would be determined according to sick fund membership and financial situation. The Jewish Agency was to make its financial contribution to Hadassah quarterly, and in the case of a budget surplus, the money would be returned to the Jewish Agency. People working for SHAREL were considered Hadassah employees and received their salaries from Hadassah. Hadassah committed to appointing additional employees at its discretion, except for the director of SHAREL, who would be appointed by mutual agreement between Hadassah and the Jewish Agency. It was also agreed that funds allocated to SHAREL by the British government would be credited to the Jewish National Council’s account for its participation in SHAREL expenditure. Representatives of the Jewish Agency, the Jewish National Council, the sick fund, and Hadassah were invited to the ceremony of signing the agreement.56 Following the transfer of SHAREL management to Hadassah, Dr. Grushka was reinstated as director of SHAREL.

Various waves of immigration brought different medical problems, creating difficulties for Hadassah in managing SHAREL as they planned. In 1946, the British policy restricted immigration to a quota of 1,500 *olim* per month, and therefore only 18,000 people arrived in the Land of Israel that year. Illegal *olim* were transferred to Cyprus. An immigrant camp was established in Ra’anana for about 500 infants and their parents who were returned from the detention camps in Cyprus. Apart from caring for the people in this camp, the activity of SHAREL was limited.57 Data from the immigrant department (*mador la’ole*) show that in 1946, a total of 18,200 Jews arrived in the Land of Israel: 3,106 *olim*, 12,706 illegal *olim* (*ma’apilim*), 1,485 tourists, and 903 returning residents.58 The British Department of Health closely monitored the *olim* and their health status. According to monthly reports from that period, about 200 people entered the port of Haifa each month. They were all found to be healthy when examined by a physician and were granted permission to enter the country.59 This division allowed the JDC to cooperate with Hadassah, with a clear distinction between their areas of activity.

Acquiring the directorship of SHAREL was a dream come true for Hadassah. The formal ceremony of the signing of the agreement was published in all the morning newspapers.60 Dr. Yassky addressed the Hadassah employees with excitement: “We have taken upon ourselves an enormous role, which will require extreme effort from each employee and each department, but I am confident that each one of you will be delighted to accept the great role…and would fully commit to helping.”61

The offices of SHAREL were located in Hadassah hospital in Jerusalem, and not by chance. The administrative management of SHAREL was assigned to H. S. Halevi from the Hadassah administration, and Ms. Zaslavsky was appointed as head nurse. Dr. Yassky appointed an advisory council that he himself headed. Members of the council were senior figures in Hadassah: Dr. Ali Davis, who was appointed deputy head, Dr. Grushka, Prof. Strauss, Dr. Halperin, H.S. Halevi, the nurses Ms. Zaslavsky and Ms. Druckman, and the district physicians.62 The Jewish Agency appointed Dr. Beharl and Dr. Yoseftal as its representatives in the Central Bureau of Hygiene Services in SHAREL.63

The shortage of hospital beds came up for discussion in the first management meeting of SHAREL. SHAREL intended to establish six camps for about 600 *olim*. Each camp was to have a clinic, hospital rooms, and accommodation for the medical staff with a tea room and a storage room. In some of these camps, space would be allocated for infant facilities and maternity rooms.64 It was agreed that three plans would be prepared for the expansion of the health services: one for building a central hospital, another for the construction of temporary barracks near the existing facilities, and the third for the expansion of existing institutions in accordance with their development plans.65

It soon became clear to Hadassah how inaccurate the early assumptions about the costs had been. Preliminary estimates had estimated the monthly expenditure per person at about 2,500 lira Eretz-Yisraelit (LEY) were wrong. Hadassah increased the estimate to LEY 40,000 per year, but in reality, the monthly expenditure was LEY 9,600. On top of that, maintaining a hospital in Atlit further increased the annual cost by LEY 108,000.66

In addition to the high costs involved in the medical management of SHAREL, Hadassah invested resources in expanding buildings and infrastructure. Hadassah anticipated that the issue of SHAREL would be discussed and its budget corrected in the 22nd Jewish Congress that was about to convene in Basel.67 The advisory committee to SHAREL had also been informed about the revised data and calculations that were presented to the Jewish Agency.68

**Rifts emerging between the collaborating parties**

The establishment of SHAREL required changes in the cooperative relationship with the Clalit Sick Fund. Some of the health services provided by Clalit became the responsibility of Hadassah. New operating procedures for SHAREL, constructed by the organizations, stipulated that each oleh must undergo a physical examination before they could receive medical care. *Olim* who were sent to camps were examined there, while those who were sent directly to permanent housing were examined by local sick fund physicians. *Olim* who did not undergo physical examination during the first month after their arrival were not entitled to receive sick fund health services.

Health services in the camps were provided exclusively by SHAREL on behalf of Hadassah. Physicians asked the *olim* during their physical examination which of the sick funds they would like to join (Clalit, Leumit, Amamit), and the Jewish Agency then insured the *olim* for the first three months after they left the camps. *Olim* who joined the sick funds were exempt from the probationary period required for other new members. Sick people and women in labor were admitted to their local hospitals free of charge, and travel expenses were reimbursed by SHAREL for patients required to travel for treatment. Each oleh who was either in a hospital or discharged was followed up by the district physician who had visited the patient in the hospital. Patients who were sent to a sanitarium for continuing care received SHAREL funding for up to 15 days’ stay, but travel expenses were not covered. Patients with severe conditions, such as tuberculosis and mental illness, did not join the sick funds, and their treatment needs were funded by the Jewish Agency until they had recovered. Emergency dental treatment was provided to the *olim* by SHAREL at their time of arrival to the country. However, SHAREL did not provide rehabilitation services (such as fitting prostheses), or treatment to the terminally ill, unless they required active intervention.69 Preventive medical treatment was provided in the camps and in the *olim* housing by Hadassah nurses. This was, in fact, the first “medical services basket” and was managed and controlled by Hadassah.70 Still, several issues were not resolved in the agreement. The available budget was insufficient to care for patients with chronic conditions, terminal diseases, mental illnesses, and tuberculosis.71

The Advisory Council for SHAREL first convened in December 1946. Dr. Chaim Sheba, from the Clalit Sick Fund, who contributed extensively to the *aliyah* and the *olim* was among those elected to serve on the council. He was later appointed as the director of the Ministry of Health.72 The Zionist Congress (the “Struggle Congress”) also convened in December 1946, and Hadassah saw this as an opportunity to present its plans for discussion and to request an additional budget. In Dr. Yassky’s opinion, the deportation of the illegal *olim* to Cyprus that month, and the anticipated arrival of more *olim* to Israel, necessitated that the Congress dedicate a session to SHAREL. Hadassah’s requests to Congress to increase its budget failed, which severely affected Hadassah’s situation, and it founded itself caring for chronically and mentally ill patients for extended periods without an adequate solution.

Although Dr. Yassky did not travel to the Zionist Congress, he was hoping that Hadassah’s representatives would be able to discuss SHAREL. He told them: “Now, more than ever, we are of the opinion that the medical team to the *olim* camps should be permanent and responsible for SHAREL. I am hoping you will forcefully present my opinion.” Dr. Yassky restated his opinion that the optimal solution was to establish a general council that would attend to the immigrant issue.74 However, a general council was established only in the 1950s.

By February 1947, representatives of SHAREL had still not been included in discussions about establishing *olim* camps and their sanitation, and a program initiated by Hadassah to build a field hospital was also frozen.75 Another unresolved issue was the shortage of medical staff, particularly 100–200 nurses required to care for patients. The situation called for fast action, but no progress was made during the first year and half of SHAREL’s existence.76 Tuberculosis was an issue of great concern to Hadassah, with a rise in the number of *olim* with tuberculosis creating a severe shortage of hospital beds.77

Toward the end of 1947, SHAREL estimated that if immigration continued at a rate of 15,000 *olim* each year, an additional 150 hospital beds for patients with tuberculosis would be required. Hadassah intended to add 100 new beds for these patients. Patients with tuberculosis remained in Hadassah Hospital on Mount Scopus for extended periods, with an average stay of more than six months. Detainees with tuberculosis were also transferred to Israel from Cyprus, and the number of hospital admissions was higher than the number of discharges. In addition, the hospitalization plan had not taken into account the many cases of bone tuberculosis diagnosed during 1947.78 Despite the increasing need for hospitalization, at the end of 1947, the budget of SHAREL was cut to LEY 120,000 for the following financial year.79 Many *olim* who were hospitalized while in camps or in immigrant housing exhausted their medical insurance with their sick find and were entirely dependent on the services provided by SHAREL.80

**Toward the establishment of the State of Israel**

In September of 1947, the UNSCOP (United Nations Special Committee on Palestine) submitted a report to the UN recommending the end of the British mandate and the partition of the land. With *aliyah* about to increase, the Yishuv had no medical solutions to the problems they were about to face. Dr. Yassky, the medical director of Hadassah, was working to establish a field hospital, Dr. Meir, the medical director of the Clalit Sick Fund, proposed a plan to decentralize hospitalization and increase the number of hospital beds, Dr. Noak from the Jewish National Council was working to establish an institution for the mentally ill, and Dr. Grushka, the director of SHAREL, raised the issue of hospitalization on various occasions. These leaders all alerted the Yishuv to the upcoming issues. However, in practice, no hospital beds were added for the *olim*.

Similar to the dire predictions voiced by the Yishuv’s physicians, the medical delegation to the deportation camps in Cyprus published a report that emphasized the shortage of hospital beds and questioned the country’s readiness to receive patients. A report submitted by Dr. Landzcorn and nurse Rebecca Linkowska (Lynn), working in the displaced persons camps in Germany, raised similar concerns. Sentiments within the Yishuv at that time were mixed—on the one hand, there was the great joy and hope for mass *aliyah*, but on the other, there was anxiety and worry that large numbers of patients would soon overwhelm the medical services. Immediate and expedited action was required by all the relevant bodies.81

Based on the experience of the preceding working year, a plan was drawn up for the absorption of 150,000 *olim*. Constructing a new hospital was no longer discussed, and instead, plans were made to increase the number of beds in the existing hospitals. At that time, the government discontinued the construction of a new hospital in the central region of the country, near Tel Litvinsky, as well as the building of a hospital for patients with tuberculosis by the Clalit Sick Fund in Kfar Saba. Hadassah Hospital on Mount Scopus required a budget increase of LEY 650,000.82

As 1947 was coming to a close, the financial state of SHAREL worsened. The organization attempted to cut its expenses, acting hastily, while at the same time paralyzing the activity of its management. No source of help or additional funds were available to SHAREL. Safety concerns on the eve of the War of Independence made it impossible to gather all the partners and resolve the difficult situation. Hadassah was forced to cover the additional deficits of SHAREL.83

Following the adoption of the Partition Plan for Palestine by the United Nations, Hadassah was busy preparing its operational plan for action after the establishment of the State of Israel.84 The Hadassah Council, which convened in May, resolved not to reduce its services and to increase the 1948 budget to US $3 million. This resolution and the increased budget allowed Hadassah to expand its involvement in providing medical services after the establishment of the State.85

The increase in military tension and the battle flare-ups in various parts of the country led to the establishment of the Military Medical Corps (SHAR), headed by Dr. Sheba. In September 1947, the Jewish National Council, the Haganah Organization, and the Histadrut Executive Committee established the Emergency Medical High Committee, whose role was to prepare the Yishuv for war. From the end of 1947, separate budgets were allocated to SHAR.86 Members of SHAREL were concerned that funds initially allocated for *olim* absorption would now be redirected to SHAR. A budget of LEY 460,000 was allocated to SHAR, while SHAREL budget was LEY 357,000. However, the leaders of SHAR, who were themselves involved in *olim* absorption, supported a uniform budgetary framework for all branches of emergency medicine by using all the resources available to the Yishuv. 87

With an increase in the number of *olim*, and 8,000 people expected to arrive from the detainee camps in Cyprus, SHAREL had to open clinics in five new *olim* camps without an adequate budget increase. Hadassah had not expected a budget increase during the war; however, it was concerned about further deterioration of SHAREL’s deficit.88 Although Hadassah was an American organization, its commitment and direct involvement in caring for the *olim* made it operate as one of the local organizations. This is evident from Dr. Yassky’s opening address to the board of directors of SHAREL, which he convened in February 1948, in which he lamented:

It is easy to say: I told you so! As you all know, for the past two years, I have taken any opportunity to point out to anyone involved in *aliyah* that we are not ready to absorb the *olim*, neither in the economic sense nor in the organizational sense, and it saddens me to say that nothing has actually been done to make us ready.89

From Dr. Yassky’s point of view, the meeting had significant results. New arrangements were made, and an additional budget was allocated to cope with the imminent liberation of the detainees from Cyprus and the increased *aliyah*. The budget deficit between October 1947 and January 1948 was more than LEY 2,500 owing to the increased number of *olim* that exceeded expectations. There were many sick people among the *olim*, mainly patients with tuberculosis, and a large number of them needed hospitalization. The dangerous security situation made it difficult to transfer patients to Hadassah safely. Based on collected data, a three-month budget for the absorption of 20,000 *olim* was calculated.90 Hadassah used its contacts with the American Consulate and with the British Authorities and attempted to ensure safe passage to the Mount Scopus hospital (we know today that this was not successful), and the Hadassah women were asked to act in Washington as well.91

**The siege of Jerusalem and its effect on Hadassah and SHAREL**

In March 1948, Jerusalem was intermittently cut off from the coastal plain region. The journey from the Hadassah hospital on Mount Scopus to the Jewish part of Jerusalem was dangerous, and most of the hospital beds were occupied by soldiers wounded in battle.92 At the same time, the *aliyah* continued growing. The absorption of *olim* during the war was difficult, and it was even harder to assess what to prepare for. Additional funding was required to meet immediate needs and for emergency supplies.93 An additional budget of LEY 60,000 was provided for a three-month period but was insufficient to meet requirements. Hadassah felt that it had reached the end of its financial capability. Going forward, Hadassah considered two options: one was for Hadassah to continue managing SHAREL, provided that the Jewish Agency committed to cover the high expenses, which were expected to exceed the approved budget (of LEY 160,000 per year); the second option was to release Hadassah from its responsibility for SHAREL. Hadassah feared that any further diversion of its own budget to SHAREL would jeopardize emergency health services at the hospital and would paralyze Hadassah’s activities.94

A month later, Dr. Yassky informed the heads of the Jewish Agency that Hadassah was reducing its participation in funding SHAREL to LEY 80,000.95 These were Dr. Yassky’s last days. Every day, soldiers from the Jordanian Legion fired at Mount Scopus, and bullets hit the hospital wards. The road to Mount Scopus was blocked repeatedly.96 Four days later, on April 13, 1948, a convoy that made its way to Hadassah hospital was attacked, and 78 people were killed, among them Dr. Yassky.

**The establishment of the Ministry of Health and the transfer of SHAREL to its management**

The issue of *aliyah* of severely ill patients, who had been cared for by the JDC in Europe, first came up for discussion when the British announced their date of departure from the Land of Israel (May 15, 1948), and as the Israeli Ministry of Health was being established. With the imminent closure of the displaced persons camps in Europe, it became obvious that these patients would have to be accommodated in Israel. During the second ceasefire in the War of Independence, the heads of Hadassah and the Jewish Agency discussed the future of SHAREL.97 A week later, an agreement was signed between the newly-established state and Hadassah, which stipulated that Hadassah would continue to manage SHAREL and the Ministry of Health would finance any budget shortfall.98 Under the agreement, an advance payment of LEY 20,000 was promised to cover the debts of SHAREL, but by mid-September, Hadassah had not received any funds. The heads of Hadassah despaired of ever receiving the long-awaited funding, and following much discussion, they informed the minister of health that from October 1, 1948, Hadassah would no longer be financially responsible for SHAREL.99 The Jewish Agency and the director of SHAREL were also informed about this change.100 Hadassah was hoping that with its abdication of responsibility for SHAREL, the Jewish Agency would again assume this role.101 The Ministry of Health, which was still being established and was preoccupied with providing health services to the many wounded in the war, requested that Hadassah continue to manage SHAREL, at least until the end of the year. Hadassah acquiesced, provided that the Jewish Agency financed any expenses that exceeded the budget.102

It looked as though SHAREL employees would be able to return to regular work. Their salaries were paid by the Ministry of Finance, and they were considered employees of the Ministry of Health. However, on March 13, 1948, with the appointment of Eliezer Kaplan as finance minister, his ministry announced that the Jewish Agency, rather than the government, would fund SHAREL. Thus, the funding situation was back to where it had started, and SHAREL was on the verge of another crisis, and this time, its employees were occupied with the post-war *aliyah*.

SHAREL operated clinics and health services in 21 camps but struggled with a severely depleted workforce and increasing requirements for hospitalization. The situation in the camps became so critical that the camps’ physicians announced they could no longer be responsible for the *olim* and were ceasing work.103

Medical services in the camps included examining health certificates, administering vaccines for smallpox and typhoid fever, testing for signs of infectious diseases, disinfecting with DDT, isolating patients with contagious diseases, and performing blood tests and chest X-rays for all *olim*. SHAREL and its management were adamant that the *olim* should not leave the camps without a medical permit, although they did not want them to be perceived as “concentration camps.”104 What was needed more than anything were services for people who could not go through the regular process of *aliyah*: those with complex conditions, disabilities, and handicaps. These services required additional funding.

**The establishment of Malben (Institutions for the Care of Handicapped Immigrants)**

In April 1949, the immigrant absorption camps housed approximately 50,000 *olim*, and their numbers were increasing daily. At the same time, the displaced persons camps in Europe were closing down, and Israel was forced to accelerate the absorption of sick *olim*. During the years 1949–1950, the magnitude of the expected *aliyah* would require the addition of 3,600 general hospital beds and a similar number of beds for patients with tuberculosis, mental illnesses, and disabilities.105

In June 1949, Dr. Grushka resigned from his role as director of SHAREL, and his deputy, Dr. Sternberg, was appointed as his replacement. The government decided to take over the management of SHAREL, and Hadassah continued to manage the pediatric unit in Rosh HaAyin.107 However, the difficulties continued to intensify, and the departure of Hadassah only exacerbated the problems.

Demands on the budget and on the provision of medical care for the *olim* were growing. The solution to these problems came from a second American Jewish organization, the JDC. The JDC expressed a willingness to establish inpatient institutions for *olim*, provided it was accepted as a full partner in the management of the service.109

During the War of Independence, the JDC had expanded its activity in Europe and in British detention camps. Much like Hadassah, the JDC helped coordinate activities and mediate between institutions in Israel and in the United States and Britain, although purportedly not engaging in political affairs. Similar to other aid organizations, the JDC also increased its involvement in the rescue of European Jews. Unlike Hadassah, the JDC did not operate within the borders of Israel until 1949.110

Four days after the first Independence Day, celebrated in May 1949, the Health Department of the JDC convened a conference in Munich. The conference discussed the difficult situation in Israel and decided to slow down *aliyah*, even though at the time, the JDC was in the process of closing down the camps in Europe and reducing the number of medical personnel. With the closing down of 28 out of the 62 camps in Europe, an immediate solution was required. The JDC decided to gather the *olim* in the larger camps and dismantle the smaller ones. It was clear to the institutions that the State of Israel would not be able to find the resources required to care for *olim* who were sick. However, pressure from those seeking to make *aliyah* was mounting, and their letters became tools in the political struggle between refugee organizations, the government, and the JDC.111

From 1949, caring for “severe medical cases” became a significant burden on the health services in Israel. These cases included patients with chronic conditions, those with mental illnesses, children and adults with tuberculosis, and the elderly whose families remained in Europe. Many of the elderly were over 60 years of age; about 200 of them were left with no relatives, and only about 200 were healthy. Another group included 2,300 disabled people who were Holocaust survivors or partisans, for whom the JDC provided professional training so they could support themselves. Activities included visiting camps and institutions, establishing a network of clinics for lung diseases, and performing extensive screening tests with the assistance of the Jewish Agency. The JDC tried to avoid hospitalizing patients in order not to separate family members and also because of patients’ mistrust of German doctors.112

It was now clear that the process of *aliyah* had to be expedited and that bringing the sick and disabled to Israel was the only viable solution. The chain of events leading to the adoption of a policy of medical selection or control and a ban on immigration of sick people provoked anger and frustration among those seeking to make aliya who tried any avenue that would allow them to enter the country. These policies also led to disagreements among the institutions. At this time, the JDC, which specialized in caring for *olim*, was searching for a new mission. The establishment and management of Malben was an opportunity for the JDC to break free from its “non-Zionist” image, and to open new pathways that would place it in a more favorable light in Israel and within its community of origin.113 At the end of 1949, the Jewish Agency, the Israeli government, and the JDC agreed to establish a new institution to care for *olim* with severe medical conditions.114

In the agreement signed, the new organization tasked with caring for *olim* with severe medical conditions was named Malben, an acronym in Hebrew meaning “Institutions for the Care of Handicapped Immigrants.” With the establishment of Malben, the geographic restriction of the JDC’s activity came to an end. It also marked the beginning of its operation in Israel, which started under the framework of Malben and was later expanded to other areas.115 Hadassah was compelled to cease managing SHAREL at the end of April 1948, the JDC began managing Malben116 in May 1948.117

As mentioned above, in May 1949, the work of the JDC in the displaced persons camps in Europe was coming to an end. The JDC expressed its willingness to begin managing Malben immediately, including the management of care for the *olim* from Yemen.118 This was a vital move because an agreement signed with the International Refugee Organization119 obliged Israel to absorb the refugees from the displaced persons camps in Europe.120

Plans to bring people with severe medical conditions to Israel were finalized at the end of December 1949. It was decided that 150 *olim* who needed nursing care but not institutional beds would be the first group to come; the next group would include patients requiring medical supervision without hospitalization (such as patients with tuberculosis), and the last group of patients who needed to be hospitalized would be brought to Israel in June-July.121

At the beginning of 1950, the JDC contributed $11 million to help finance *aliyah*, down from $23 million for the same purpose the previous year.122 The JDC also had to notify the government of its reduced financial support, which had resulted from a decline in donations collected by the United Jewish Appeal during the first three months after signing the agreement to establish Malben.123 However, the JDC’s activity actually expanded during this time, and it continued to manage the care of the “severe cases” hospitalized in Italy, Marseille, and Algeria until arrangements were made for them in Israel.124 Members of the JDC felt that while they were doing their best, their work did not receive the recognition it deserved from the public.125

At the end of the 1950s, the Ministry of Health decided that Malben would care for *olim* with chronic conditions who had become ill before they arrived in Israel. A patient’s referral to Malben was to be made within 18 months of their arrival in Israel, or when they could no longer pay for their treatment. This did not include people with mental illnesses, tuberculosis, and chronic conditions who needed urgent hospitalization and were removed from the JDC’s care. At that point, patients were referred to Malben by the Ministry of Health offices, which supervised hospitalization and treatment. An investigatory committee was established, comprising a representative of the Ministry of Health, who chaired the committee, and other representatives from Malben and the sick funds.126 Thus, ten years after the establishment of Israel, the JDC was still involved in caring for “handicapped” *oli*m.

After 26 years of activity, Malben ceased operations, transferring its responsibilities to the state. The significance of Malben’s contribution throughout this period went well beyond the role it had been initially assigned. Malben cared for a target population of *olim* from high-risk groups, who could not be helped by the regular, state-run health system.127 In 1953, the number of *olim* diminished, and SHAREL was winding down its operation. However, as routine medical services for *olim* came to an end, the care of the sick and disabled remained a challenge. This population was cared for by Malben, operating under the auspices of the JDC, until 1976.

**Discussion**

The first question I raised in this article was whether management of key areas of the health services by Hadassah and the JDC had an impact on the state’s attitude toward the medical aspects of *olim’s* absorption. What emerges from this article is that the contribution of the two organizations was critical to the decision to bring all the *olim* to Israel. I describe the ambivalence of the Yishuv toward the American organizations. However, the Yishuv desperately needed the physical and economic support these organizations offered. Hadassah and the JDC experienced great difficulties raising finance and recruiting personnel but did whatever they could to continue their work even in times of adversity and shortages. A letter sent from Eliyahu Dobkin to the management of the Jewish Agency describes discussions with the JDC regarding the treatment of *olim*. According to this letter, an agreement was easily achieved when discussing the operation of the JDC outside the country, but disagreements were common regarding its activities within Israel. What tipped the balance was the need for the JDC’s assistance and its organizational experience. At this time, the JDC was refusing to fund activities within Israel. Jewish Agency officials were concerned, or as the writer puts it, “prophesized,” that the JDC would agree to operate in Israel in exchange for recognition and official consent to its activities.128 This issue was no longer valid in the face of economic hardship. Hadassah was in a similar position in funding and operating SHAREL until the establishment of the state in 1948. It advised, more than once, that it would discontinue managing SHAREL because of the economic crisis in the United States. However, Hadassah continued to manage and fund SHAREL even after the establishment of Israel. The situation was described in a book written by the director of SHAREL, Dr. Sternberg:

SHAREL was established after World War II, and its declared mission was to provide full medical services to the many *olim* who survived the Holocaust, and it was necessary to establish a special organization …that would provide medical and rehabilitation services for these *olim*. There was no doubt that the most suitable organization was Hadassah, given its affinity for American Jewry and for the destiny of the Holocaust survivors.129

In 1947, Hadassah was cut off from its base on Mount Scopus, its director had been murdered, Jerusalem was under siege, and at the same time, massive immigration was getting underway. Every month, about 10,000 *olim* were arriving on the shores of Israel. This period in history has been called “the great *aliyah*.”130 In summary, it could be said that without the help of these organizations and others, the government would have been unable to change its policy of selective *aliyah* to non-selective *aliyah*, which opened the gates for anyone who wished to come to Israel.

The second question examined in this article was whether the activity of Hadassah and the JDC in caring for the *olim* contributed to the fact that 74 years after the establishment of the state, the wording of Israel’s National Health Insurance Law still does not include services such as geriatrics, psychiatry, and rehabilitation in the services basket.

The National Health Insurance Law was approved by Israeli legislators in 1994 and came into effect in January 1995. The guiding principle of the law was that health insurance would be based on the principles of “justice, equality, and mutual assistance.” The enactment of the law revolutionized the relationships between the sick funds and the insured, and between the sick funds and the government. A basket of services was defined and entrenched in legislation. According to the law, every resident is entitled to receive a basket of basic services, with the Ministry of Health remaining responsible for psychiatry, geriatrics, public health, preventive medicine, and mental health. These services, listed in the Third Appendix of the law, were to become the responsibility of the sick funds after an interim period of three years. However, the plan was only partially enacted, with services of mental health transferred to the sick funds in 2015.131 This was not the first attempt to bring health insurance regulation under statutory law. Proposals had been submitted and rejected during the British Mandate, and with the establishment of the state, it seemed that the time had come to draft a law. A bill was submitted, proposing that health services should be provided by the sick funds operating in the country, with the Ministry of Health formulating the policy, supervising its implantation, and assuming responsibility for preventive medicine and inpatient services for the mentally ill and those with chronic diseases.132

Ben-Nun et al. suggested that the involvement of the Ministry of Health in providing medical services, as stipulated in the National Health Insurance Law, was rooted in history. Public health services were transferred to the Ministry of Health after Hadassah reduced its activity in the Land of Israel during the financial crisis in the United States in the 1930s. According to Ben-Nun et al., the areas of mental health, nursing homes, and rehabilitation were undeveloped during the first half of the twentieth century, and for this reason, they were ignored by the sick funds. It appears that the JDC managed these areas until the middle of the twentieth century. The authors further indicate that following World War II, the mental state of many Holocaust survivors mandated their hospitalization. This was also true for a high proportion of older people and those with disabilities who needed institutional care. The JDC provided these services in the early years, as described in this article. The National Health Insurance Law sought to regulate these services as well.133

In 1978, an agreement to transfer Malben institutions from the JDC to the Government of Israel was signed, with a commitment to preserve their original character. The JDC pledged to provide annual funding of NIS14 million until 1981, while the government promised to use the money exclusively for the operation of Malben institutions.134 According to the original agreement for the establishment of Malben, the JDC was to cooperate with the government and the Jewish Agency in funding and managing the institutions until the end of 1951, but in fact, the JDC managed Malben until the end of the 1970s, and continued to fund the care of vulnerable patients until 1981. In 1988, the government decided to form a National Commission of Inquiry to investigate the functionality and efficiency of the health system. This followed a lengthy and severe crisis situation that had already begun before the 1980s.

An article by Shvarts, Ben-Nun, and Oz reviews many years of government activity and legislation attempts in great detail, describing committees that have been established and bills that have been rejected for many different reasons. The National Health Insurance Law was finally passed in the 1990s, and the areas that the JDC had managed were not included in the reform. As for Hadassah’s effect on the law, the Commission of Inquiry recommended integrating private medical services into public hospitals, following the model used in Hadassah’s hospitals. However, the law did not include the integration of private medical services into state-run hospitals, and the discussion about employing the Hadassah model is still ongoing, while private medicine is evolving in various models that are not discussed here.

**Summary**

American Jewry supported the medical and social absorption of *olim* via Hadassah and the JDC, two organizations with different ideologies that were nonetheless similar to each other. The two organizations had an essential role in establishing and providing health services for the *olim* in Israel and in the displaced persons camps and British detention camps. Although the organizations made a distinction between political and philanthropic support, in hindsight, it can be seen that the help they provided assisted in advancing the Zionist movement toward its goal—the establishment of a Jewish State.135 In the Introduction, I described the unique position of American Jewry and how they viewed the establishment of Israel and their support for *aliyah* as important missions, although not necessarily wanting to make *aliyah* themselves. This approach allowed the two organizations to support the *olim* without becoming politically involved or asking for anything in return. In examining the activities of Hadassah and the JDC during the formative years of the state and its institutions, it can be seen that they worked so closely with the state institutions that they were no longer considered outsiders. This attests to their organizational skills and activities, which intensified during the formative years. SHAREL and Malben, the institutions established by the two organizations, made an essential contribution to the success of the health system, which was reflected in health measures—reduced infant mortality, eradication of epidemics, and medical insurance.

In its early days, Hadassah built the preliminary infrastructures, such as registered nurse training programs and worked to establish a medical school. Hadassah was also involved in the establishment of a public health system and preventive medicine in Israel. Since its inception, Hadassah regarded the promotion of the Yishuv’s goals as paramount, which was a view shared by other organizations, such as the Clalit Sick Fund and other women’s organizations. The JDC chose to focus on vulnerable and disadvantaged groups – the elderly, disabled, and handicapped people – and built the first institutions in Israel to care for these populations. In doing so, it established the infrastructure for health and social services in Israel and contributed to training, nursing and medical staff.

The view that these organizations held towards *aliyah* was different from the views of the *olim* and the people of the Yishuv.136 During the difficult times, the state’s leaders were eager to accept help from the organizations, although they always regarded them with suspicion and ambivalence. This attitude, however, did not discourage the organizations.

In hindsight, we can conclude that the State of Israel owes an enormous debt of gratitude to Hadassah and the JDC for mobilizing their resources in a time of need, contributing physically and economically to the absorption of *olim* in Israel, and providing medical care in Israel and overseas. American Jewry, seeking to be involved in the establishment of a homeland for the Jewish people, found a pathway to realize their vision, and a way to contribute and become a meaningful partner in the process. The organizations, through their involvement, found meaning to their vision and mission in Israel and the United States. At the end of the post-war mass *aliyah*, the two organizations continued to operate beyond their declared mission. Although they were both established as organizations of aid and rescue, they soon became providers of medical and social services in Israel. Their unique contribution is still evident today in health, welfare and social services, in the way services are provided, in preventative medicine, and in legislation.