Chapter Five

Kupat Holim and Mass Immigration

Who Will Care for the Health of the Immigrants?

The decision of the Israeli government to place medical services for immigrants in the hands of an independent government-run agency, totally separate from the Kupat Holim system, forced the sick fund to formulate policy and procedures on their further care for immigrants. While Kupat Holim representatives were supposed to sit with Dr. Sheba and representatives of the municipal emergency medical committees to coordinate medical work in immigrant concentrations throughout the country, such cooperation among all the health agents existed only on paper. In practice the Immigrant Medical Service collaborated only with the Military Medical Service, and simply ignored Kupat Holim as if it didn’t exist.

The agreement between the Jewish Agency and Kupat Holim stipulating that all immigrants would receive medical insurance gratis from Kupat Holim, health care underwritten by the agency, continued to function even after the establishment of the state, however, no procedures existed as to how immigrants who wished to continue their membership in Kupat Holim after the first three months of free coverage must proceed. Consequently, Kupat Holim had to formulate and set forth criteria for membership in the sick fund and the Federation of Labor for such newcomers. Policy also had to be set regarding eligibility for membership of immigrants with existing serious medical conditions such as the disabled, the chronically ill, and the mentally frail and elderly applicants.

At the beginning of 1949, Kupat Holim began to hammer out procedures for continuing its work with immigrants and for admitting new members to the sick fund. Since the first wave of newcomers had been sent to find shelter in homes and villages vacated by Arabs who fled or were expelled in the course of the war, Kupat Holim opened clinics in almost every new point where immigrants settled. In June 1949 there were already thirty-eight sick fund clinics in various geographic concentrations of new immigrants. Most clinics were staffed by a doctor and a nurse. In most cases the physicians themselves were new immigrants who underwent three months training—primarily language training in Hebrew. At the end of the training period the doctor was promised
housing adjacent to the clinic in the new settlement where the immigrant doctor would be posted. Such housing—in times of acute shortages with tens of thousands of persons housed in temporary and flimsy shelters—was part of the physician’s remuneration and served as an attractive bonus for immigrant doctors who themselves were struggling to adjust. Most of the doctors who joined Kupat Holim were either older physicians (usually age fifty and above) or doctors who for other reasons, were unsuitable for the draft and had received exemptions. Kupat Holim also launched a campaign to mobilize nurses for work in its clinics among immigrants, both assisting the doctor and engaging in preventive medicine, hygiene, and other forms of health education among residents. In addition to ongoing medical assistance provided by Kupat Holim clinics, the sick fund also established and ran Tipat Chalav (which translates as “A Drop of Milk”) mother-and-child prenatal and postnatal care stations inside Kupat Holim clinics, a service underwritten by the minister of health. The clinic doctor, in most cases, was expected to provide medical services on a rotation basis to neighboring settlements, as well.\(^2\)

In January through March of 1949, Kupat Holim operated five medical processing stations in the intake camps that carried out general medical checkups, lung x-rays and serological blood tests for venereal disease.

With the establishment of the central intake camp Shaar HaAliyah south of Haifa on the coastal plain, where most immigrants were subsequently processed upon arrival, Kupat Holim decided to established and post a special medical team in Shaar HaAliyah to coordinate all the medical examinations in the camp. Medical checkups were limited to diagnosis of tuberculosis and venereal diseases (syphilis and gonorrhea), and blood tests as needed.\(^3\) Thus, Kupat Holim brought two mimeograph machines into the camp to conduct lung diagnoses and established an onsite laboratory to conduct blood tests. All children age eight and above were x-rayed and all immigrants fifteen years of age and above underwent blood tests for venereal diseases. Once newcomers were screened for these contagious diseases, the other stages of physical checkups and classification of immigrants were carried out at local residential Kupat Holim clinics in the place where the immigrants were sent to settle. The logic behind the sick fund’s arrangement was that in such a manner, it would be possible to examine a thousand persons a day and immediately pinpoint those who presented a risk—preventing contagious newcomers from exposing others in the Shaar HaAliyah camp to communicable diseases while awaiting a more thorough but time-consuming check-up procedure that would slow down the process.\(^4\) The checkups were one of the clauses in the agreement signed by the Jewish Agency with Kupat Holim as a service-provider for immigrants. The sick fund committed itself to provide test results within twenty-four hours to ensure immediate isolation and care of those with active tuberculosis. The average time spent at Shaar HaAliyah was one week. The IMS was responsible for vaccinating immigrants against
typhus and smallpox. The immigrants were forbidden to leave the intake camp until they completed this checkup and immunization process—all the more so since conditions in transit camps and elsewhere in the country were marked by crowding and inadequate sanitation, making identification of those with diseases such as active tuberculosis an absolute imperative if the outbreak of epidemics was to be prevented.

In the months March through June 1949 Kupat Holim conducted such preliminary medical checkups on one hundred thousand immigrants that passed through the Shaar HaAliyah camp, including thirty thousand chest x-rays and twenty-nine thousand blood tests. The staff was comprised of twenty-one staff members—only one a physician. The average examination took ten to fifteen minutes; if there was any hint of disease, the individual was summoned for re-examination.

The preliminary medical data on immigrants was designed to assist in providing short-term care and in the future, to assist Kupat Holim determine the medical status of individuals who requested to join the fund—or, as Kupat Holim’s critics charged, to prevent those with chronic diseases and existing disabilities from joining the sick fund.

Issues such as confidentiality, the use and misuse of data and concepts of patients’ entitlement to medical information about their person were not raised for discussion at the time—not by the immigrants, nor by those carrying out the physicals. One of the chief critics of Kupat Holim’s actions in the immigrant camps was Dr. Avraham Sternberg, Dr. Grushka’s deputy director in the IMS, and later its director. Steinberg charged:

As strange as it may seem—indeed during those difficult days at the outset of 1949, another national medical institution was operating in the same immigrant camps themselves, it was the General Sick Fund. In one of the worst places, in the Natanya camp, I met a doctor from Kupat Holim who was engaged in examining the immigrants with the assistance of a nurse and a clerk who recorded the results. And for what? In order to determine medical limitations in receipt of people for membership in Kupat Holim. This was absurd under the terrible conditions then. The mighty Kupat Holim machine operated with maximum utility, without consideration of people and their torments. After all, medical assistance was realistically a precious commodity and needs were tremendous then. And Kupat Holim doctors were used to ensure that the institution would not fail, God forbid, in accepting a member and giving rights that [the person] was not entitled to according to Kupat Holim’s regulations and this, when most of the examinees were unable to grasp for what and why they were signing [their names], and how much unnecessary hardship would be caused them in the future on the penchant of a rash and unsubstantiated notation.

Yitzhak Kanev categorically rejects the charge: “There was never such a thing. Kupat Holim was the only institution that reached the maabarot and
the new immigrant settlements. Kupat Holim doctors did great works, above and beyond what others did."7

Despite the harsh tones and serious charges against Kupat Holim, and an insinuation that the sick fund withheld rightful entitlements from immigrants because of narrow institutional interests, Steinberg admitted: “Kupat Holim did great things in this area, even if its clear intention was to fully reveal these sick people in order to limit their rights in the future in accordance with [the sick fund’s] regulations and in order not to have to carry out later examinations when the immigrants were already spread out from one end of the country to the other.”8

Intentionally or unintentionally, Sternberg failed to recognize the fact that in practice, at the end of the three months free coverage, most of the immigrants who wished to do so, were able to pay the joint dues and eligible to join the sick fund without almost any restrictions, and to receive full medical services. This was the case, despite the medical data concerning previous medical conditions that Kupat Holim had at its disposal from its work in the intake camps and immigrant encampments. In most cases, it was the immigrant’s employer that determined whether an immigrant would join Kupat Holim; that is, membership in the Federation of Labor through one’s place of employment—at a time when most places of employment were “union shops” with collective wage agreements, was the decisive factor, not an individual’s health status. Membership in the sick fund was one of a series of privileges that came with federation membership. Furthermore, the small number of immigrants who wished to join Kupat Holim that the sick fund rejected on medical grounds (usually due to mental illness or disabilities that the sick fund did not treat directly in any case) were referred to the Federation of Labor to be addressed in the framework of the federation’s disability fund, which took upon itself to address the needs of several hundred mentally ill immigrants, immigrants with paralysis and tuberculosis. The disability fund’s services were funded out of federation dues, along with outside assistance from Hadassah and the Jewish Agency, with the government paying 100–150 Israeli pounds for every hospital bed or rehabilitation bed. Only a small number, primarily mentally ill and frail and disabled immigrants fifty years old and above, deemed unsuitable for the disability fund framework, were referred for government-sponsored medical assistance and welfare services, beyond the federation’s own health and welfare institutions. In many respects Sternberg’s harsh criticism of Kupat Holim was unwarranted, at best a tempest in a teacup. Just how detached Steinberg’s claims were from realities on the ground is clearly reflected in the fact that in 1950 Kupat Holim provided full medical insurance to 60 percent of Israel’s citizens, Jews and Arabs. By 1954, the sick fund was providing insurance to approximately 90 percent of the country’s citizens. Examination of Kupat Holim records from the period did not uncover even one letter totally withholding membership in the sick fund from a person on
the basis of information gathered in the course of conducting checkups of masses of immigrants in the camps. The information was primarily used by the sick fund to formulate policy, forecast hospital bed demands and plan the location of clinics and primarily—to settle financial accounts with the government based on epidemiological data gathered by Kupat Holim in the course of processing immigrants. The individual immigrant did not ‘suffer’ and was not discriminated against in any way as a result of this process. As for mental ill and frail individuals, in any case the sick fund did not provide such services—even to its veteran members. As during the madate period, these services were provided through the auspices of the Federation of Labor’s disability fund or were the responsibility of the mandatory government, a role passed on to the Israeli government (see figure 5.1).

In May 1949, as noted above, the Knesset conducted its first discussion of health services in the year-old State. Discussion focused on the shortage of hospitalization services and the emergency services program drawn up by the Ministry of Health to cope with growing health needs. Another issue on the agenda was additional budgeting for health—questions concerning closing the gap in doctor and nursing staff and the role of local municipal councils in addressing the shortage. In the course of the debate the government was criticized for appointing only a part-time minister, who was responsible for Interior and Immigration, as well as the Health portfolio—although the Ministry of Health objectively needed a full-time minister. In addition, Knesset members harshly criticized the lack of suitable care for those with TB and the dangers this presented to the public, and insufficient care in other sectors—particularly new mothers and children, as well as the inefficacy of the Ministry of Health in organizing medical work among the immigrants. Most of the speakers cited in particular the duty of public institutions such as Hadassah, WIZO, the Joint and the Jewish Agency to assist the Ministry of Health provide medical services for immigrants, but they categorically ignored Kupat Holim. Kupat Holim—the organization that at the time insured 40 percent of the country’s inhabitants—objectively, was the body with the most experience in organizing medical services on a large scale, yet it was only mentioned in passing in the course of debate. The only delegate who related to Kupat Holim as a core agent in the health field that could be assistive in creating practical solutions to alleviate prevailing hardships was MK Hannah Lamdan from Mapam.

If the government would have adopted a [policy] line of support and encouragement of health institutions, the situation would be different. I’ll take Kupat Holim as an example, a health insurance fund that provides assistance to about 350,000 souls, among them many immigrants. And Kupat Holim alone is not able to carry this burden of absorbing sick immigrants. If the Ministry of Health would depart from this framework of narrow-mindedness and view an
institution such as Kupat Holim as an important popular insuring institution, it would encourage Kupat Holim and the local councils. The Government alone can’t solve the question. If it will continue along the path it is taking, who knows when we will reach a more or less orderly situation.9

The Ministry of Health, which had only begun its operations a few months earlier, was not interested in the assistance of its “big sister,” Kupat Holim, which not only was much larger than the ministry in its early days; Kupat Holim hardly hid its readiness to take upon itself responsibility for organizing health services in the state. The Ministry of Health wanted to build itself as the central agency controlling health matters on behalf of the state on its own, without any partners. Therefore, the only form of cooperation that could be considered from the ministry’s standpoint was collaboration with institutions that did not threaten the ministry’s hegemony or compete with it, such as Hadassah, the IDF, WIZO, and the JOINT. In 1949, Hadassah’s operation had been paralyzed by the loss of its primary power base, Hadassah Hospital on Mt. Scopus, which was left at the end of the 1948 War as an enclave completely surrounded by Jordanian-held territory, unable to function as a public institution or assist the Ministry of Health. The JOINT, on the other hand, focused most of its operation on immigration, not absorption.

Dr. Avraham Sternberg presented a different picture of reality in the Knesset debate, beyond his previous criticism of the sick fund in other forums. According to Sternberg, Knesset members participating in the debate over health services did not have a proper grasp on the situation and did not understand the relative clout of the medical agents operating in
the health field and immigrant medical services. In his view, Kupat Holim was not being discriminated against; rather, the immigrants were being short-changed by the sick fund evading responsibility for treating them. In Sternberg’s estimation, Knesset members should have demanded that Kupat Holim gird itself to care for the immigrants and not let the sick fund dodge this mission. Sternberg held that ignoring Kupat Holim’s duty to assist in hospitalization and organization of health service, as reflected in the Knesset debate, was in Kupat Holim’s vested interests, for it placed the weight of responsibility on the shoulders of the Ministry of Health although the Ministry was largely helpless, unable to take any significant action to rectify the situation. In either case, Kupat Holim was not required to take any action, and Knesset members participating in the debate did not consider Kupat Holim’s participation in formulation of health policy to be a necessity, nor did they consider the sick fund responsible for providing medical services to immigrants in the camps, even if, in practice, it was doing so in the field.

Despite the almost total disregard of Kupat Holim by the Ministry of Health—which did not view the sick fund as a partner in decision-making on health matters—particularly immigrant policy, nevertheless, Kupat Holim did not treat the situation on the ground lightly or consider it someone else’s concern.

**Hospitalization Shortages and Health Policy**

On May 19, 1949, parallel to debate in the Knesset, Kupat Holim’s Medical Council (Moetza HaRefuit) convened to discuss “The Question of the Hospitalization Situation in the Country and Worsening of the Sanitary Situation in the Camps and New Points of Settlement of Immigrants.”

The council concluded that care for immigrants in the camps and immigrant neighborhoods, as was the case at the time, was insufficient. Medical services for the immigrant would be expanded by introducing medical specialists, enhancement of medical equipment and establishment of sick rooms on a large scale within the camps themselves. . . . The Medical Council brings to the attention of the [Jewish] Agency that insurance of new immigrants in Kupat Holim for medical assistance for three months does not contain a complete solution for ensuring medical assistance to immigrants. Under prevailing conditions most of the immigrants don’t have [the means] to continue their independent membership in Kupat Holim after the first three months, and they are left without any medical assistance, a situation that intensifies incidence of morbidity and the danger of the outbreak of disease. The Council recommends to the absorption institutions to extend immigrant insurance for an additional period.10
The Kupat Holim Medical Council warned in particular of the dire shortage of hospital beds that had already been discussed in the Knesset, calling for immediate steps to add thousands of hospital beds under Ministry of Health funding. The medical council itself announced that it would work towards expanding Kupat Holim’s own hospitalization facilities and even initiate the building of new hospitals.

In June, the shortage of hospitalization was again debated in the Knesset, with particular emphasis on the shortage of beds for children. Knesset Members Rokach and Lavon complained that despite the Knesset’s decision to approve special funding for hospital beds for children, the Ministry of Health had not added even one bed, and of the hundred-and-forty infants and children from immigrant camps that were in need of hospitalization in the first week of June, only forty-one were accepted; the rest had been sent back to their homes without suitable care. The distress in pediatric care was exacerbated by the outbreak of an epidemic of jaundice that affected some twenty-seven thousand children. The Ministry of Health, however, was slow to respond—whether due to the shortage of resources and overload of services in so many fields in the country—all demanding a solution; whether due to the ministry’s lack of experience in large-scale management, or whether due to lack of funding. Whatever the reason, the tempo of expanding hospital bed capacity in government-run facilities lagged well behind acute needs.

It was clear to both the ministry and the sick fund that an all-out effort was needed to increase hospital capacities—both to meet the needs of the immigrants who were already in the country, and for future immigration. The sick fund management, under the leadership of Soroka, understood that if Kupat Holim could not provide an adequate solution to the shortage of hospital beds for immigrants in the short run, then responsibility for such would be transferred to governmental agencies, diminishing the status of the sick fund. This worry was amplified by the rapid growth of the Tel Letvinsky hospital and the underlying competition that had already developed between Soroka and Dr. Sheba over who would dominate the hospitalization system in the country. Soroka understood that if the sick fund took steps on its own initiative to add hospital beds in its institutions and if it provided suitable care for immigrants in need of hospitalization, this would strengthen Kupat Holim both in the short-run and in the future. The Ministry of Health sought quick cheap shortcuts to provide hospital beds in existing structures and institutions, most void of suitable infrastructure for a hospital—a strategy epitomized by the rapid growth of Tel Hashomer (Letvinsky). By contrast, Kupat Holim knew only one way of solving the shortage—building high-standard hospitals in a given time frame of two to three years in the hopes that needs would not change in the interim and the newly-constructed facility would be suitable to needs and operate accordingly. Soroka also hoped that the construction of a streamline and innovative institution would
attract outstanding doctors and prevent the slow loss of doctors to government institutions.

The decision of the sick funds to build more hospital facilities in order to meet the needs of immigration and to reinforce its position as a dominant player in the health field, was reinforced by the appointment of Dr. Meir—who had been the medical director of the sick fund and Soroka’s close colleague for many years—to the position of director-general of the Ministry of Health. The appointment of a Kupat Holim person to the most senior management position in the health system aroused expectations of improved relations, a share in decision making on a national level and greater government funding for Kupat Holim, replacing the competition and enmity of the past with a positive and practical collaborative relationship between the ministry and the sick fund.

Yet, despite the expectations that Dr. Meir would bring the two bodies closer together, the Ministry of Health, primarily its division heads, continued to go it alone and even estranged themselves from Kupat Holim. While Dr. Meir tried to change policy towards the sick fund, the division heads and the ministry’s other senior employees refused to collaborate with Kupat Holim, charging that the latter only sought the good of the sick fund, neglecting the needs of the ministry. Thus Kupat Holim remained isolated. The minister of health as well, struggling to establish his own political position and establish the authority of his ministry in the health field, was not eager to nurture a close relationship between his people and Kupat Holim’s. As a result, most of Dr. Meir’s time and energy was invested in serving as a go-between and coordinator between the minister and his senior officials, and Kupat Holim’s senior management, all the time forced to address attempts from within the ministry to diminish his own authority and clout within the ministry, because he was viewed as a Kupat Holim implant within ‘their’ ministry.11

In June Soroka announced that Kupat Holim intended to launch an expansion program of its hospitalization capacities “to catch up with growing needs in the wake of the immigration.” The program called for adding a wing to the Beilinson Hospital, opening a maternity facility in Kfar Saba, expanding the maternity facility in Rechovot and building a new hospital adjacent to Beilinson Hospital. According to the heads of the sick fund, the new hospital was designed to provide hospital beds for TB patients among the newcomers. In addition the sick fund announced it was opening additional convalescent homes, expanding existing convalescent homes and adding additional clinics in the immigrant camps. In order to provide a suitable solution for sick immigrant children, Kupat Holim said it would send three pediatrics specialists to the immigrant camps to serve as advisors and instructors for local physicians and nurses in the camps. The gesture was made possible by “temporary waiving of supervision by the doctors of children’s houses in the kibbutzim, while
recognizing the urgency of providing rapid assistance to the immigrant children in the camps.\textsuperscript{12}

But allocation of doctors did not solve the problem of insufficient medical services for immigrants, nor did it stop the public criticism of Kupat Holim. The daily press, particularly the center and right-wing media which devoted ongoing reportage of conditions in the immigrant camps, was in the habit of quoting various parties that, on one hand, accused Kupat Holim of not doing enough for the immigrants, while others charged that the medical services the sick fund was providing were a mobilization ploy designed to increase membership in Kupat Holim and the Federation of Labor. These charges were primarily leveled by Knesset members from the non-socialist General Zionist Party who focused their charges on hospitalization shortages and raised this issue time and again in Knesset debates. In August 1949 Knesset member Gil from the General Zionists attacked Kupat Holim’s activities in the camps and even demanded that an investigatory commission be appointed to examine its conduct.

The workers’ sick fund announced this week in the Sunday [edition of] \textit{Davar} that it has absorbed in six months, January to June this year, more than 120 thousand immigrants. That is to say, more than 240 thousand immigrants over a year. For these immigrants Kupat Holim receives from the government and the [Jewish] Agency, in addition to the [physical] examination fee, insurance payments for three months to the amount of close to five Israeli pounds per family and three lira per single person, as they exit the camp. The workers’ sick fund is the one responsible for the health of the immigrants for at least the first three months. With the monies it receives from the Agency and the government, it is Kupat Holim’s duty to provide medical assistance and suitable hospitalization for immigrants whom it has insured. But in practice, I saw primitive medical arrangements in the abandoned villages and shortage in the proper number of additional beds in Kupat Holim hospitals for immigrants, who almost all are automatically registered by the [Jewish] Agency in the workers’ sick fund. . . . I call for a parliamentary commission being appointed that will investigate the situation in the provision of medical assistance domain and arrangements for hospitalization of immigrants by the government in general, and by Kupat Holim in particular."\textsuperscript{13,14}

Gil’s criticism was not new and in essence repeated criticism he and his colleagues had voiced in the first discussion of the issue in the Knesset in April of the same year. The frequency with which General Zionist Party leaders raised the health issue in the Knesset, particularly in relation to the role of Kupat Holim, reflects not only the critics’ genuine concerned with health issues, but also, even primarily, vested interests: the masses of new immigrants joining the Federation of Labor and the federation’s sick fund—Kupat Holim after their initial three month period of free
health coverage. Whether the decision to join was totally a matter of free choice, or whether it stemmed from other considerations, such as lack of any other health provider in many outlying areas, or the enhanced prospects for employment in labor-owned industries that federation membership carried along with medical insurance, clearly the swell in membership rolls was advantageous to both the federation’s and Kupat Holim’s status and political clout. The General Zionists, it should be kept in mind, had their own sick fund at the time—the General Zionist Sick Fund, which later changed its name to the Merkazit (Central) Sick Fund, today the Meuchedet (United) Sick Fund. The General Zionist Sick Fund operated mainly in urban areas, with medical services provided by private practitioners. While the General Zionist Sick Fund had no desire to provide services in the immigrant camps, nevertheless, it feared that Kupat Holim’s presence would lead to the Federation of Labor’s sick fund dominating the health services field, pushing all of its smaller competitors out of the market entirely. The General Zionists’ positions also reflect the first steps taken by the Kanev Commission in early 1949, to formulate a plan for legislation of a national social insurance plan that would include compulsory health coverage. The General Zionists opposed such health coverage on principle, and as a matter of self-preservation. In any event, a compulsory health system would have amplified the clout of Kupat Holim in light of such a plan’s broad outreach, and diminished the standing of the General Zionists’ own sick fund and the independent private practitioners who not only worked with the General Zionists’ sick fund, but were an important political constituency of the General Zionist Party at the time.

Thus, Gil’s criticism of Kupat Holim’s work among the immigrants was marred to a great extent by vested political interests, even if it was correct from a factual standpoint as to prevailing conditions and flaws in the quality of health service in the camps.

Mass immigration and the potential of thousands of newcomers receiving services from Kupat Holim also impacted on the deliberations of the Federation of Labor’s coordinating committee, executive council, and secretariat. In April 1949, the coordinating committee decided that immigration would be the first item on the agenda of the Federation of Labor’s National Convention, scheduled to take place during Passover week.

The Federation of Labor’s Policy

In August 1949, the federation’s executive council convened to discuss the Federation of Labor’s plans for the coming year. The central theme of deliberations indicated, in essence, that they were “not interested that the government will maintain the organizational institutions of the federation
and the [federation’s] Union Section will absorb immigration, explain to immigrants the federation’s way, educate them, teach them Hebrew and absorb tens of thousands of new members into the federation, whom we are absorbing day and night. We are not pleased with this [kind of] absorption of immigration.”

The coordinating committee’s motion “to change the existing method of collecting dues, as well as a suggestion to change the internal allocation of dues among the [federation’s] institutions” was a key issue, including reduction of joint dues by an average of 18 percent, thus easing the financial burden on the individual worker or employee. The goal of reducing dues was clear: “By lessening the dues burden we will be able to gain new members.” The goal evaluation of the coordinating committee as presented during discussion was that the new joint dues per worker at its new levels would range from 4.5 percent to 5.5 percent of the wage earner’s gross salary. At the same time, it was decided that the reduction would not affect level of services members received from the federation or the scope of medical services provided by Kupat Holim. Soroka and Dr. Tova Yishurun-Berman (who had been appointed medical administrator of the sick fund in place of Dr. Meir), conducted a long and stormy discussion with members of the federation’s executive. But the issue discussed was not the need to find an immediate solution in the short-run to Kupat Holim’s growing budgetary strait and difficulties in organizing health service for immigrants. Rather, discussion focused on the future of the sick fund and the options it faced in light of the realities created by mass immigration and the need to absorb so many people. In essence, hardships in hospitalization due to shortages of physicians and nursing staff wasn’t even discussed. At the same time, formulation of federation policy was discussed, policy that would require all the public construction companies to erect clinics in every immigrant neighborhood they build, in proximity to already planned public buildings—the kindergartens, schools and general store. Soroka and Berman protested that present finances were so dire that the sick fund would be unable to staff and operate all these new clinics—all the more so, when the federation was cutting budgets, rather than increasing them to cover such expansion. In response, the coordinating committee took responsibility that in time of distress at Kupat Holim, [the committee] would take care of securing an easy credit loan, in order to help Kupat Holim extricate itself from [its] strait. A proviso to this decision was that Kupat Holim was not permitted to curtail at all the medical services it provided at the time to the member. . . . If it would become evident that reduction in dues was liable to damage the ability of Kupat Holim to maintain its services in full—in accordance with the approved plan—the Coordinating Committee would consider it its own duty to find a way to help Kupat Holim to get through the transition period.15
Along with such soothing words for Soroka and Berman promising that the committee would serve as a safety net for the sick fund, the Kanev Program for compulsory health insurance was also cited in discussion. Its implementation—deemed to be just a matter of time, would transfer a lot of the responsibility to the government, and reduce, to a certain extent, the responsibility and financial burden placed on Kupat Holim. Aharon Beker even underscored that

We read in recent days that the Minister of Labor, comrade Golda Myerson, announced in the Knesset that she hopes or promises that in the current year, in the coming months, the first law for social insurance will be introduced in the Knesset. . . . The first law will surely include health [insurance] for the federation’s organized labor and the poor in the country and for all employees. It is entirely possible that if the Knesset will succeed in this, as for Kupat Holim’s budget, the effect will be many times more than the sum we are talking about.

The federation preferred to relate to the great future awaiting just around the corner—tens of thousands of potential dues-paying members from among the masses of new immigrants arriving in the country, attracted to join the federation due to Kupat Holim’s services. Yet, at the same time, the coordinating committee did not provide any suitable solution to the immediate problems facing the sick fund. In the long-run, the principle set forth by the federation in 1949—that every new immigrant neighborhood would have a Kupat Holim clinic as an integral part of local public services, impacted positively on federation membership rolls. A rapid expansion in membership was registered in the first half of the 1950s when building of permanent housing was at its apex.

The immigrants sought to avail themselves of Kupat Holim’s services since practically it was often the only accessible source of primarily medical care in their vicinity, particularly on the periphery. In the Lachish development region in the Northern Negev and in the Galilee, federation-run building companies were the dominant player building new immigrant housing—allowing the federation to maintain the principle of neighborhood primary care by mandating construction of a local Kupat Holim clinic as part of the infrastructure, and in such a manner to create a de facto monopoly on primary health care in such communities.

This principle was preserved even after the government decided that a number of immigrant camps would become new immigrant housing apartment blocks. In the wake of the plan, Kupat Holim approached the Immigrant Medical Service and requested that the clinics that had operated in the camps be turned over to Kupat Holim so it could provide services to newcomers being housed in the complexes who were insured by the sick fund during their first three months in the country, and until it would be
decided who would be responsible for providing medical care to these points of settlement in the future. In the course of taking over the clinics, Kupat Holim demanded that Tipat Chalav mother-and-child prenatal and postnatal care be administered by Kupat Holim as well from the same clinics, instead of Hadassah, and Kupat Holim was willing to wrestle with the Ministry of Health on this issue. Jenny Tushtein, a member of the Ministry of Health’s Preventive Medicine Committee, wrote Kupat Holim directorate member Ben-Yitzhak:

> Your telephone message from July 16, 1950, that Kupat Holim insists on opening a mother-and-child station in the new immigrant neighborhoods in the Tichon region, including Kerem Maharal, Ein Hod, Geva, Hacarmel, Ein Haiyalah and Atlit, surprised us . . . We charged the Hadassah Medical Federation with investigating the possibility of establishing stations in these points for preventive medicine . . . We request that you explain to us what propelled you to contest this decision of the Preventive Medicine Committee.\(^{19}\)

But Ben Aharon knew what was behind this move. In the margins of the copies of the letter that he passed on to the other members of the directorate Ben Aharon noted “It is the opinion of Dr. Berman that we should not give up this area . . . Kupat Holim’s appeal and details on the content of the appeal you will receive from Dr. Berman at the next meeting.”\(^{20}\) In the end, Kupat Holim only received a number of stations, but succeeded in reaching an understanding with the Ministry that operation of mother-and-child stations in immigrant neighborhoods would be coordinated with the sick fund, and they would not be transferred solely to Hadassah. In the mid-1950s, when Hadassah transferred all of its mother-and-child stations to the Ministry of Health, the ministry asked Kupat Holim to provide these services in isolated and distant settlements within its own clinics to save the expense in staff and equipment of operating separate facilities. The ministry undertook to compensate Kupat Holim for the work of the station—a service that was mandated by law. Yet, in the eyes of the public-at-large, who for the most part were unaware of the internal arrangements between the sick fund and the government, prenatal, and postnatal care was perceived as a service provided by the federation and its sick fund. All the more so, from the perspective of local residents, Kupat Holim appeared to be the only health agent showing any concern for their health needs. The transfer of clinics into the hands of Kupat Holim and operation of mother-and-child prenatal and postnatal care in immigrant neighborhoods, even on a temporary basis, clearly enhanced the image and the status of Kupat Holim in the eyes of newcomers, who came to view the sick fund as the core health-provider in their new country.

Within a few short years, by 1955, the decision of the Federation of Labor’s executive to use Kupat Holim as a core mobilizing tool to encourage new immigrants to join the federation through rapid expansion of services,
transformed the sick fund from an organization serving 43 percent of the population, into an almost exclusive health organization, serving 68 percent of the population.\textsuperscript{21}

\textit{Kupat Holim’s Ascendancy—The Situation in the First Year}

In October 1949 the supervisory committee of Kupat Holim convened to sum up the first year of work in immigrant camps and to formulate plans for the foreseeable future. All twenty-two members of the supervisory committee were present, together with nine members of Kupat Holim’s directorate and two delegates from the Kupat Holim physicians’ committee. The discussion focused on a number of issues that in the eyes of the participants were considered critical to the future of the sick fund, against the backdrop of mass immigration: how to address ongoing care of new immigrants in the camps and immigrants in newly-constructed immigrant apartment blocks; how to deal with the “frightful” immigration from Yemen; how to address shortages in hospitalization capacity; how to deal with tensions between veterans and newcomers in setting the sick fund’s priorities; what form should the working relationship among the government, Kupat Holim and the Federation of Labor take; and how to deal with the fiscal problems and shortage of personnel that limited the ability of the sick fund to function properly. Soroka opened the meeting with an overview of the situation, saying:

According to a cautious appraisal, by the end of this year we will reach 473 thousand souls in Kupat Holim, compared to 325 thousand we had the past year. These figures envelop the fundamental problem of Kupat Holim. . . . Kupat Holim’s population has grown by 50\% and more . . . There are times that performance is delayed due to lack of plans and at time due to lack of means. Everything that we manage to carry out is the product of overcoming changes in the above factors. We still have before us a great feat of establishing buildings and housing for institutions and medical institutes. Our work plan for the year 1949 includes an addition of 220 beds. . . . We must make sure that Kupat Holim will add beds, otherwise we will lag behind in providing this assistance to our members . . . In [the intake camp] Shaar HaAliyah all the immigrants that went through were examined. On the other hand, all those who did not manage to go through the ‘Shaar,’ only a portion were examined. We expanded the service of central clinics for tuberculosis.

Third wave of immigration (from Yemen)—there has yet to be such a frightful immigration. All the immigrants from ‘Magic Carpet’ suffer from severe malnutrition, 30\%–40\% have malaria, a large percentage with trachoma and skin diseases.\textsuperscript{22} The change in the ethnic composition of Kupat Holim requires that we adjust our \textit{modus operandi}. . . . In 150 points of settlement we established
medical aid stations, and all this despite the lack of vehicles, telephone contact and so forth . . .

In government hospitals members of Kupat Holim do not receive beds or they receive them in tiny degrees . . .

During the past year there were attempts here and there to empty Kupat Holim of its substance. There were ‘advisors’ who wanted to transfer certain roles from Kupat Holim to the state.

Kupat Holim lags behind from the standpoint of providing for the medical needs of its members. To date we have managed to fulfill the most urgent needs. It’s our duty to improve the medical aid by giving special assistance.

Kupat Holim was well aware of the challenges it faced and who were its competitors, how it must plan its steps, and what other players in the health field might need to be confronted or challenged. Even the solutions that Kupat Holim formulated, such as expansion of special services for Yemenite newcomers, organization of mobile clinics in ambulances to combat trachoma and establishment of daycare centers under the supervision of a doctor and nurse, along side mother & child prenatal and postnatal centers, were realized within a short time. The only nagging question that accompanied these endeavors from the start was how to bridge the gap between needs and capacities—particularly how to deal with the shortage of professional personnel which constituted one of the main barriers according to Soroka, and impeded the development of the sick fund and prevented expansion of hospitalization capacities and clinics in keeping with the demands of mass immigration.

The Shortage of Medical Personnel

One of the core questions that Kupat Holim was forced to grapple with when it entered the immigrant camps was the question of medical personnel, primarily nursing staff. Most of the medical work focuses on health education, care of chronically ill and daily assistance with advice and information for people in distress—tasks that needed to be carried out by trained nurses.

In Soroka’s estimation, Kupat Holim needed seven to eight employees per thousand members in order to provide full medical services. In practice, it was possible to supply only half that number, and the shortage of registered nurses was particularly acute.

Shortage of Nurses

The backbone of Kupat Holim services in the camps was its nursing staff, without whom it would have been impossible to expand services or even
operate them. There were three reservoirs of nursing personnel that Kupat Holim (and the health system as a whole) could draw upon: the first, graduates of Kupat Holim’s and Hadassah’s nursing schools; the second, immigrant nurses who underwent short intensive training that would enable them to organize services in the camps, and other immigrant concentrations elsewhere in the country; the third, short intensive training program to train practical nurses who could help in points of settlement where there were not enough registered nurses, who could provide assistance under close supervision of a registered nurse.

The medical service would not have been able to function without the registered nurses who carried out both administrative and organizational functions, parallel to responsibility for ongoing medical services. Although there was a shortage of registered nurses, in the first months of 1949, Kupat Holim mobilized nurses already employed in Kupat Holim who were willing to volunteer to go out for short periods to assist in the national absorption effort. Nurses were mobilized from kibbutzim. Both campaigns were, at best, only a temporary stop-gap solution. The number of nurses willing to live permanently in relatively isolated transit camps or immigrant towns was very limited. Only a handful of veteran nurses agreed to leave their families and homes or to find alternative work for their spouses so they could accompany them, in order to devote themselves to working among the immigrants. Moreover, the large number of new hospitalization facilities established for the most part near large cities, increased the demand for nurses in hospitals under far more attractive conditions. As a result, many nurses preferred to opt for a hospital setting rather than setting out to serve in an immigrant camp in the boondocks.

Consequently, medical service in the immigrant camps, and particularly that provided by Kupat Holim, suffered from a chronic shortage of nursing staff. Makeshift conditions, rapid turnover in staff, and the ongoing shortage of registered nurses in general, all had a negative effect on the scope of medical services and access to them.

In July 1949, a short time after taking up his post as director-general of the Ministry of Health, Dr. Meir put the issue of the nurse shortage in the immigrant camps on the public agenda. He described conditions on the ground, noting that

With all the difficulty in obtaining suitable nurses, one can say with absolute certainty that in the cities of Tel Aviv and Haifa, the situation is far easier than in other places and all the more so within the camps: The nurses are not eager to leave the city, married nurses are not able to leave the city, nurses who are mothers of children we ourselves can’t send into the camps. . . . Much to our sorrow, over the years a ‘particularism’ and aspiration for ‘Spartanism’ has developed in well-established institutions, and I must say with sorrow that for many years the Tel Aviv Municipality was not the last in this aspiration.
I thought innocently, that the great awakening among the pubic-at-large in regard to disease and infant mortality would extricate the institutions from this ego-centricism and much to my sorrow I was proved wrong.

According to Meir, at the time the thirty-one clinics operated by the Ministry of Health in the camps—a population of seventy-thousand persons—were staffed by only thirty-four registered nurses. The only backup was sixty-six practical nurses and caregivers (metaplot) who underwent intensive short-term training in childcare, “who in their entire lives had never seen how to care for a baby.”²⁵ Ben-Gurion noted that the shortage of trained nurses was not solely the problem of the civilian sector, noting “There are no nurses, not even for the needs of the army.” Dr. Meir demanded that the hospitals in the cities and Kupat Holim allocate one registered nurse or a nursing student for a month’s work in the camps during the summer as a stopgap measure, until the committee discussing the crisis could complete its work and formulate a policy for mobilizing nurses for the camps. Dr. Meir forewarned that those institutions that would not respond positively to his call, would face nurses being drafted from among their staff according to need and without any prior notice. When a nurse failed to show up from Tel Aviv, based on claims that for the Tel-Aviv municipality’s part, there was “a supreme effort of the municipal hospital in Tel Aviv” already afoot, for “maximum care for immigrants,” and therefore they could not send a nurse, Dr. Meir replied to Rokach, the mayor of Tel Aviv: “I place all the responsibility for the results of this refusal on you.”²⁶

Kupat Holim suffered from a shortage of nurses even more than the Ministry of Health. At the time, the sick fund operated two nursing schools with a total student body of eighty students, each graduating class no larger than thirty students. In addition to these two schools there were special programs for training nurses for x-ray clinics that graduated twenty-five students every two years, and a program for “nurses for physical medicine.” Under normal conditions, the number of graduates was sufficient to fill the ongoing needs of the sick fund, but mass immigration and need to immediately increase the scope of medical services—at both the hospital and clinic level, changed the entire situation creating an immediate demand for a large number of nurses.

The most acute shortage was at the clinic level. Kupat Holim’s working principles called for the sick fund to maintain a clinic in every point of settlement—as was the case in kibbutz and moshav settlements prior to mass immigration. While in Tel Aviv it was possible to relax this principle and meet prevailing exigencies by merging clinics and establishing split shifts where a clinic served different neighborhoods at different times of the day, this was not practical in rural areas on the frontier. Generally these clinics were budgeted and operated based on minimal staff that could not be stretched; mobilization of a nurse or doctor to serve a frontier village meant
closing a clinic in a veteran settlement. In 1949 clinics and medical aid stations were established in a hundred and fifty different points of settlement, in both immigrant camps and immigrant neighborhoods, creating tremendous pressures on nurse staffing and the sick fund’s ability to function.

In order to try to close the gap in nursing staff, Kupat Holim opened another class at its nursing school adjacent to Beilinson Hospital bringing the sick fund’s total nursing student body to 126 enrollees. Parallel to their studies, the nursing students all worked at the Emek Hospital or at the Beilinson Hospital, thus partially alleviating the shortage of nurses.

In addition a large number of practical nurses and infant caretakers were trained; while professionally their medical knowledge was limited, the practical nurses were able, after minimal training, to assist in the operation of clinics in the camps, helping to alleviate the shortage of personnel. Consequently, when the Ministry of Health requested that Kupat Holim transfer a full quarter of its graduates to the Ministry in order to care for the Yemenites brought by airlift, the sick fund was unable to meet the request. “Kupat Holim doesn’t want to give nurses,” Ben-Gurion wrote in his diary after Giora Yoseftal, the treasurer of the Jewish Agency, complained to the prime minister regarding the special problems in absorbing the Yemenite immigration. “Dr. Tova Berman, the doctor who replaced Dr. Meir, should be contacted,” wrote Ben-Gurion. “Kupat Holim also promised a fourth, but it isn’t providing.”

In the months January–December 1949 Kupat Holim nurses conducted more than twelve thousand house visits of pregnant women and infants in the immigrant camps and in new agricultural settlements populated by immigrants; this was in addition to their regular work in Kupat Holim clinics and in addition to the operation of the fifty-two Tipat Chalav mother-and-child clinics that the sick fund maintained throughout the country that conducted a hundred-and-twenty-thousand home visits in 1949. Thus, it seems that Kupat Holim’s refusal to give up a quarter of its graduates was unfairly perceived as arbitrary and selfish when, objectively, Kupat Holim simply could not respond positively to the request without undermining vital services for immigrants it was barely able to provide with its own staff.

**Shortage of Physicians**

Another difficulty with which Kupat Holim was forced to grapple was the shortage of medical specialists who were willing to devote themselves to treating immigrants. In April 1950 the doctor community in the country stood at 2,801 physicians. Five hundred and forty were women doctors, half were aged fifty and over, and only 40 percent had a specialty. Some two thousand general practitioners—most over fifty years of age, were employed
in existing frameworks (the Ministry of Health, Hadassah, Kupat Holim, and the IDF Medical Corps). Only six hundred physicians were under age forty; this group was, in essence, the only genuine reservoir for physicians able to serve in rural villages and kibbutz settlements, and new immigrant neighborhoods and development towns. But the same number of doctors was needed to staff expanding hospitals, to maintain a 1:15 ratio between physicians and hospital beds.²⁹

Dr. Meir’s appraisal of the situation was that the public health system needed another eight hundred full-time doctors immediately, just to meet current needs. The doctor shortage in the public sector was so severe that in January 1950 Knesset Member Ami Asaf, a member of the ruling Mapai party, introduced a bill designed to bolster efforts to ensure medical services in immigrant camps and requested that the Minister of Health Shapira relax requirements for a license to engage in medicine, and permit the director of medical services to issue temporary licenses to practice medicine in settlements in need. The purpose of the law was to attract medical students at the School of Medicine in Jerusalem to apply for unfilled positions for doctors in public service in immigrant camps and outlaying settlements, before they formally completed their studies, forgoing completion of their hospital residency requirements. In order to prevent undermining the level of medical practice, it was suggested that the permits be limited to six months. Although the Minister of Health was well aware of the acute shortage of doctors, Shapira did not immediately support the bill. After investigating the issue in depth the minister of health did not categorically reject similar legislation, although he stressed that in his opinion it would be better for all sides if the graduates would complete their residency and gain valuable hands-on experience, before being sent to care for new immigrants, if a decent level of medicine was to be preserved.

Despite the high demand for doctors in the public health services, close to eight hundred doctors chose to engage solely in private practice, with no institutional ties whatsoever. While most did not enjoy a full-time livelihood, they declined to leave the cities to practice medicine in the immigrant camps or on the periphery. Consequently, the daily newspapers carried conflicting stories that on one hand described the shortage of medical personnel due to the influx of masses of immigrants and the “hunger” of the public health system for more doctors, while at the same time reporting the on “severe lack of work among the doctor public” in the country.

The shortage of skilled doctors for work in the immigrant camps and afterwards in the maabarot that replaced tents and shanties with sturdier but substandard housing (wooden prefabs and small cinderblock dwellings) had another dimension: competition in attracting specialists to Kupat Holim. Because the reservoir of doctors was limited, and the number of immigrant doctors who were suitable and available was
also limited, Kupat Holim personnel in the camps were in the habit of approaching doctors employed by the Immigrant Medical Service and attempting to lure them to join the sick fund—sparking resentment in the IMS which itself was grappling with a shortage of medical personnel for its operations. In March 1950, Dr. Sternberg wrote an angry letter to Dr. Tova Yishurun-Berman complaining about the sick fund’s employment offers to IMS’s doctors.

Again it has happened that Haifa Kupat Holim people have approached a doctor of ours in the Pardes Hanna Immigrant Camp and offered him work in Haifa (to Dr. Segal). I repeat and request that you ensure that the agreement between us will be upheld, that is to say only a letter from you to us obliges us. I request therefore to inform the Haifa District that they must stop partisan arrangements.

After the sick fund failed to comply, and the regional physician of the Shomron District offered Dr. Nerson, head of the pediatrics department at the Pardes Hanna Hospital to transfer to Kupat Holim’s clinic in the town of Hadera, Dr. Sternberg again wrote, “I demand from you clear orders that will prevent repeat of cases such as this on the part of Kupat Holim proxies, otherwise we will have no alternative but to prevent by ourselves meetings and arrangements such as this.”

Sternberg’s anger was understandable. First of all, Dr. Nerson was the only pediatrician on staff, and had he accepted the offer, the Pardes Hanna Hospital would have been left without a pediatrician and been forced to close its department. Secondly, the IMS itself not only suffered from a shortage of doctors, its wage scale was 30 percent lower than Kupat Holim’s. There was a genuine danger that doctors in the IMS would be unable to withstand the temptation of transferring to Kupat Holim to improve their own lot. Thus, Sternberg had no choice but to stand in the breach to prevent defection of its best doctors to greener pastures. The loss of even one IMS doctor was likely to set in motion the desertion of others, attracted by Kupat Holim’s higher salaries and less stressful working conditions, depleting the IMS of its most vital staff members—a situation Sternberg could not let happen.

The general shortage of doctors and the competition in staffing between the IMS and Kupat Holim was accompanied by a third factor—hardships resulting from the labor dispute that broke out towards the close of the 1948 war between the Kupat Holim management and the sick fund’s physicians.

With the outbreak of the 1948 war, Kupat Holim doctors had agreed to freeze a number of their wage disagreements and moderated other demands for improvements in working conditions as part of the doctors’ contribution to the war effort, recognizing the dire straits of the Yishuv and the need to put national interests above personal issues. For its part, the sick fund preserved the rights of the doctors who volunteered for military service or were
drafted, promising to return them to their positions at the end of the war. The agreement of the sides to put their differences on the back burner for the interim did not, however, eliminate or reduce the tensions between the management and its doctors. The tensions that resulted from the failure of the Beilinson Hospital doctors’ struggle in November 1947 (discussed in chapter 1) was amplified by the competition that developed at the beginning of 1948 between Kupat Holim and the emerging Military Medical Service, and towards the close of that year—between Kupat Holim and the doctors at Tel Letvinsky, and between Kupat Holim and the Ministry of Health. In mid-1949 tensions went from bad to worse with the establishment of the first duly-elected government (March 1949) which led to up scaling the Ministry of Health to full operation and the loss of doctors previously employed by Kupat Holim to other medical institutions such as the IMS and newly-established government-run and IDF medical corps-operated hospitals.

Competition between Kupat Holim and the other health organizations logically should have impacted on the institutional identification of Kupat Holim doctors, nurturing their solidarity as a separate sector from physicians working for other institutions; in fact, Kupat Holim doctors’ primary identification was with their national professional organization—the Israeli Medical Federation (IMF), an umbrella organization of all physicians, and less with their place of employment—Kupat Holim. Discussions of wages and working conditions between the sick fund’s management and its doctors usually went beyond what was typical of employer-employee negotiations; they became a nationwide debate in which the IMF and various political parties who believed they had a stake in the issues took part—such as the Progressive Party or the General Zionists party.

1949 opened with Kupat Holim investigating every possible avenue in order to address the health needs of masses of immigrants, against the backdrop of severe shortages in trained personnel in general and the draft of many young doctors into the Medical Corps that stretched the sick funds ability to function to the limit. Despite this, in March 1949 the remaining Kupat Holim doctors operating the sick fund’s network of clinics passed a resolution at their annual convention demanding the work week be reduced to a six-hour workday: “With all the importance of this question for the institution, for Kupat Holim members and our institution’s doctors, we did not raise the practical discussion out of consideration for emergency conditions, but today with a return to normalcy and with the date of our Convention approaching, we do not see any avenue before us other than a joint inquiry in the executive.”

In August 1949, after the Federation of Labor’s executive did not immediately respond to the demands of the doctors, the council of the Kupat Holim doctors’ organization declared its decision, including the demand for shorting the workday of doctors: “The Council stands behind the decision of the
last convention of Kupat Holim doctors on a six-hour workday for all doctors and authorizes the national committee to enter into negotiations towards realization of this in stages.”

The target date for completion of negotiations with the management of the sick fund on actualization of the demand was set for September 1949—that is, almost immediately. Along with its demand for reducing the workday, the council also demanded payment of a thirteen-month salary check—that is, an end-of-the-year bonus equal to one month’s salary. Despite the ultimate tone of the demand, the doctors did not threaten to resort to sanctions or a strike. In October, a month after the date the doctor’s had set for meeting their demands, the issue was brought for discussion at a meeting of the supervisory commission of Kupat Holim during its annual meeting with Kupat Holim’s directorate. Two representatives of the doctors’ committee participated, Dr. Borstein and Dr. Feller, as well as Dr. Tova Berman, the medical director of the sick fund who was also a member of the Kupat Holim directorate, and Dr. Shatkai who was also a member of the executive. As expected, the Kupat Holim directorate refused to accept the demand, and the issue was transferred for discussion in the Federation of Labor’s executive. Dr. Feller’s suggestion “to freeze assistance in the hospitals and convalescent homes and increase the assistance in the clinics... expanding assistance to membership-at-large is far more important than providing assistance to a seriously ill individual” and his claim that “the benefit of the member and in the name of aid and economy, the number of work hours of doctors should be cut,” were also not passed. The physicians’ demands, as raised during the meeting, were totally out of line with the horrific shortage of personnel discussed at the same meeting—and all the participants roundly criticized the doctors’ position. Members of the executive not only took the doctors to task for their specific demands, but also for their attitudes towards Kupat Holim in general and their refusal to serve in immigrant camps and rural settlements.

It is hard to fathom the motives of the Kupat Holim doctors in demanding shortening their work week as well as receiving a significant salary bonus, in view of the situation in the country, in the health field in general, and the sick fund in particular—hardly normal times by any measure. On the other hand, since November 1947, when the Beilinson doctors’ revolt ended, the sick fund doctors had frozen all their professional demands for three years, and had not renewed calls for improvement in their wages since 1947. It may be that in the doctors’ minds, the close of the War of Independence and the establishment of the first elected Government of Israel signaled a return to normalcy and therefore they decided to restate unresolved issues. It is also possible that the development of two large doctor communities parallel to the sick fund—both in the medical corps and the Ministry of Health, were perceived as warning light. That is, Kupat Holim doctors
may have feared that their status and work conditions would be jeopardized should these other groups make demands before they did, leaving the issues raised during the Beilinson revolt up in the air. The absence of any minutes regarding discussions that preceded presentation of the doctors’ demands leaves this question open to speculation. Whatever the motivation, Kupat Holim could not accept the doctor’s demands. Times had hardly returned to normal, and in any case such far-reaching changes would have only intensified the economic straits of the sick fund. This was doubly so since the doctors’ working conditions were anchored in a collective wage agreement and their demands were not limited to the work of physicians in clinics or in immigrant camps. Consequently, any gains would have been across the board. Moreover, improvement in the doctors’ working conditions was likely to spark similar demands among other sick fund employees.

Due to the preferred working condition of Kupat Holim doctors, Dr. Sternberg really had a good reason to worry that his doctors would be attracted to seek employment with Kupat Holim.

Medical Services in the Maabarot

At the outset of 1950 there were more than a hundred thousand persons living in immigrant camps under harsh and crowded conditions. The unbearably Spartan conditions were further exacerbated by the pending arrival of even more Jewish refugees—Jews from Arab countries being pressured by repressive Arab regimes to leave, the first waves from Iraq and North Africa. Creation of more stable living quarters for masses of immigrants was a national imperative.

In March of the same year, Levi Eshkol, then head of the settlement division of the Jewish Agency, raised the idea of establishing what came to be known as maabarot—transit camps designed to serve as an intermediary solution until permanent housing could be erected. The plan was to establish such maabarot in proximity to veteran settlements; the latter would provide educational and health services, and old-timers would assist the newcomers to learn the language and to find employment in the local market—thus paving the way for the immigrants’ gradual absorption into the labor market. Eshkol initially called for taking ten thousand families out of the camps and relocating them in places where there was work. Afterwards he expanded his proposal “to dismantle the camps and disperse the immigrants [throughout] the country.” In debate within the government, there were a number of ministers who voiced worries that it would be difficult to get people to leave the camps voluntarily and such a campaign would demand a large degree of coercion, even use of physical force. In any case, it was clear to all the members of the cabinet that there was no alternative.
In mid-1950, the government started to transfer immigrants from the camps to newly-constructed maabarot or to change the status of some of the camps and convert the camps themselves into maabarot by adding sturdier housing (mostly wooden prefabs) and public services. The alteration in status required organizational changes that would enable the immigrant camps to function as semi-permanent settlements—that is, as maabarot (Rosh Haain camp became Rosh Haain Maabara). In 1950, fifty-six immigrant camps (out of sixty-two) underwent conversion as maabarot. The conditions in thirty-seven of them, where there was no running water, no electricity, were particularly harsh. In addition there were fifty-two working villages on the periphery—rural agricultural villages and development towns established by the Jewish Agency’s settlement department by May 1952. By May 1952 the number of maabarot had risen to 111, and the number of maabara residents to a quarter of a million souls.

From the Immigrant Medical Service to Kupat Holim

According to plan and in keeping with the agreement between Kupat Holim and the Jewish Agency for the sick fund to provide medical services during the first three months after an immigrant’s arrival, Kupat Holim was supposed to be responsible for organizing medical assistance services in the maabarot in place of the IMS. Since the maabara was the permanent place of residence of the immigrant, responsibility for the health of the residents became Kupat Holim’s responsibility. The IMS continued to operate in the temporary immigrant camps—particularly Shaar HaAliyah that remained the primarily intake camp where newcomers underwent medical checkups and processing before being sent to other housing accommodations.

On the surface, transfer of responsibility for health services in the maabarot to Kupat Holim was natural, at least in terms of the way the agreement between the sick fund and the Jewish Agency was construed. At the same time, it was clear to all that there was a ‘political bonus’ for the sick fund that came with the territory. In January 1951, well aware of the broader impact of work in the maabarot, Kupat Holim Leumit approached Dr. Sheba, at the time director-general of the Ministry of Heath, requesting that the Leumit Sick Fund be allowed to open clinics of its own in the maabarot.

Sheba responded, writing David Melamadovich, the secretary-general of the Leumit Sick Fund:

The problem here is not medical, but public. On the other hand in that the agreement with Kupat Holim regarding the maabarot was, to the best of my knowledge, not taken by the Ministry of Health but rather by the Jewish Agency. As for the heart of the matter, I request that you consider whether the
suggestion of there being two services in one maabara is good, realistic from the standpoint of materials and personnel. Lastly, it is no less clear to me that redundancy will cost a lot of money to the Yishuv, but these considerations, of course, are totally to the point. Therefore I hope that you will understand that the address for discussion of this problem is not the Ministry of Health.\footnote{Indeed, the Leumit Sick Fund appealed to the IMS, which subsequently permitted Leumit to open clinics in the maabarot. Leumit’s request was not a sudden affair, void of planning. Since 1948, Leumit had a special department that dealt with new immigrants and operated clinics at Shaar HaAliyah and at Atlit, near Haifa. Leumit tried to make the immigrants aware that they were entitled to join whatever sick fund they wished after the first three months of free coverage by Kupat Holim underwritten by the Jewish Agency. While certain parties in the government frowned on Leumit’s operation in the camps and tried to prevent them from operating there, the fact that the health and welfare portfolios during these years were not in the hands of the ruling Mapai party prevented barriers placed before Leumit. In the mid-1950s, Leumit was even granted the same government funding that Kupat Holim enjoyed. As a result of its work in the immigrant camps and afterwards in the maabarot, approximately fifteen thousand immigrants joined the Leumit Sick Fund in the years of mass immigration—although a combination of inertia, hegemony (the latter not solely in the health field either), and a host of attractive perks for immigrants, prompted most immigrants to remain with Kupat Holim.}

In June 1950, in concert with the IMS, Kupat Holim began to take over medical services in the maabarot. The first camps turned over to the sick fund were the Talpiot camp and the Machane Israel camp (in Jerusalem), and Natanya camp (between Tel Aviv and Haifa). According to the agreement between Dr. Sternberg and Soroka, it was stipulated “that all medical personnel (doctors and nurses) would be placed at the disposal of Kupat Holim.” The sick fund would pay their salaries and after a probation period, the sick fund would decide whether to accept each of the former IMS doctors as a rank-and-file employee of Kupat Holim. It was also agreed that the medical equipment in the camps would be transferred to Kupat Holim until the sick fund could arrange for its own equipment, or that it be left permanently—if the sick fund decided to purchase the equipment from the IMS. A similar arrangement existed in regard to buildings and use of the Magen David Adom ambulance.\footnote{The underlying principle was that the transfer of authority and infrastructure in all the camps would be orderly and fully coordinated between the parties. Medical personnel would be transferred as needed. As for hospitalization, since Kupat Holim could not fulfill all the needs of immigrants from the maabarot, it was decided that the Ministry of Health would continue to allocate beds for immigrants in the government's...}
general hospitals. The infant daycare and houses in the maabarot, particularly those serving Yemenite immigrants, were to remain the responsibility of WIZO and other organizations. The doctors staffing the infant houses were to be budgeted from among the Ministry of Health’s contingent of physicians.

From the dearth of correspondence from the late 1950s between the IMS and Kupat Holim concerning transfer of responsibility for medical matters in the maabarot to the sick fund, it seems that despite occasional hitches and despite the negative sentiments remaining from tensions and competition between the IMS and Kupat Holim in past years, the first stage of the transfer was carried out with any political clashes. While there were exchanges between the sides with comments such as “Natanya announced that despite the summary with Dr. Sternberg, the medical instrumentation was removed from Beit Lead, and we object to this” or “I want to remind you that the furnishings and equipment from the Natanya camp (transferred on July 1, 1950) and Rosh Haayin (transferred on August 6, 1950) has yet to be returned to us,” yet the number of exchanges of this kind were small considering the complexity and scope of the endeavor.

It should be noted that the IMS quickly internalized the fact that responsibility for medical services for immigrants in the maabarot had been transferred to Kupat Holim. The IMS did not try to hold on to these functions by force or undermine in any way the smooth transfer of authority. It responded immediately when problems arose. At the same time, the tone of the correspondence reveals a certain degree of satisfaction at the situation in which the sick fund found itself: If Kupat Holim had been overly eager to take over full responsibility for health matters in the camps, the IMS could hardly be expected to wring their hands in anguish if the sick fund now found it may have bit off more than they could chew. Yet, the IMS did not seek to make matters worse by complicating the handover.

**Health Entitlements for Immigrants by Kupat Holim**

Following the transfer of health services for masses of immigrants in the maabarot onto the shoulders of Kupat Holim, the sick fund, for the first time, published a document entitled “Rights of New Immigrants.” According to the Kupat Holim directorate, the immigrant was not only entitled to three months of free coverage, in keeping with the agreement with the Jewish Agency: an immigrant was exempted from paying membership dues in the following three months if the person was unemployed, and immigrants enjoyed a 40 percent discount for the following nine months, if they joined the sick fund (and the Federation of Labor). Kupat Holim stipulated that the immigrant was entitled to extra privileges in health services compared to
veteran members and new members who were not immigrants. For instance, new immigrants were entitled to treatment by a doctor or a medic, medications, physical therapy, x-ray and radium tests, special treatment, surgery in the clinic and hospitalization due to disease without any additional payment. New members who were not immigrants faced a two to six month probationary period of limited coverage, until they were entitled to such services. New immigrants were also exempt from payment for delivery costs in maternity wards during their first year, vaccination, supervision of school health services and Tipat Chalav pre-natal and post-natal care. Moreover the caseload of doctors treating new immigrants was set at 350 to 650 sick fund members, while other doctors were expected to bear a caseload of 1,000 to 1,800 members.\textsuperscript{42} In the report that accompanied the letter of immigrant entitlements, the executive cited that the cost of the special benefits for immigrants to the sick fund constituted 60 percent of the cost of the service per immigrant. The difference was covered from other sources within the federation, or simply added to operational deficits.

Despite Kupat Holim’s readiness and willingness to shoulder the burden, responsibility for the maabarot plunged Kupat Holim immediately into a harsh shortage of staff and means of transportation. “Kupat Holim needs doctors and vehicles” was a common headline in the daily press. One such article reported, “Due to the shortage of vehicles many doctors working in distant points (particularly in the Negev) waste their time in queues or waiting for hitches. Kupat Holim demanded the government approve 100 vehicles for doctors, but only 25 were authorized . . . Kupat Holim is in need of an addition of 200 doctors.”\textsuperscript{43} Skilled doctors willing to work in the maabarot were, however, few and far between, and government assistance with vehicles was limited.

One of the first steps taken by Kupat Holim after entering the maabarot was to expand informational work (hasbara) among immigrant residents by all means at their disposal—both to increase the number of immigrants who would extend their membership in Kupat Holim and to enhance cooperation between patients and caregivers in Kupat Holim. In addition to organizational content, Kupat Holim also took steps to disseminate health information designed to raise hygiene levels and quality of childcare. Doctors and nurses were expected to lecture on health matters beyond their regular work hours, and the staff conducted a rotation system for lecturing among the camps. Thus for instance, in June alone, there were twenty informational lectures in moshav settlements populated by new immigrants in the Galilee and the Negev.\textsuperscript{44} Parallel to this, the Information Dissemination Department also broadcasted programs on hygiene twice a week on the radio in various languages, and in addition to this, a special program designed for Yemenite immigrants in Hebrew as part of a feature entitled “Yemenite immigrants.”\textsuperscript{45} The programs for Yemenites reflects both the
sick fund’s naiveté and paternalistic attitude towards the immigrants Kupat Holim took responsibility for. While their intentions were good and in certain areas such initiatives were objectively justifiable, it is questionable whether anyone among the Yemenite immigrants listened to the “hygiene corner” that the Information Dissemination Department broadcasted on the radio. Many Yemenite Jews indeed knew Hebrew, but it is improbable that any had a radio in their Spartan dwellings in the maabarot.  

_Tipat Chalav Stations in the Maabarot_

When Kupat Holim received responsibility for the maabarot and their residents, the sick fund, Hadassah, and the Ministry of Health had to decide who would continue to operate the Tipat Chalav stations and the information dissemination centers for female immigrants. The sick fund was prepared, in principle, to accept responsibility for Tipat Chalav, integrating this function into the operation of its clinics. Tipat Chalav and hospitalization in maternity wards for pregnant immigrants was the ministry’s administrative and fiscal responsibility; transfer of actual operation of the Tipat Chalav stations to the sick fund in return for budgets from the government for this service would help economize the running of Kupat Holim’s clinics and ease its budgetary problems. At the same time it was not clear whether the sick fund had the staff needed to add this service to its operation in all locations. Nor was it clear whether Hadassah would agree to be relieved of this function. In the overall plan for transferring responsibility for the maabarot to Kupat Holim, the IMS, and the Ministry of Health had committed themselves to coordinate operation of Tipat Chalav stations in the maabarot with the sick fund. Thus, in December 1950, Dr. Jenny Taustein, a civil servant responsible for mother-and-child services in the Social Work Wing of the Ministry of Health, requested that Kupat Holim pass on to her a list of maabarot where the sick fund requested to operate Tipat Chalav stations, including the personnel who would carry out this function and the number of hours that would be budgeted for each station. In its reply, Kupat Holim provided a list of forty-three stations in maabarot and new immigrant settlements where the sick fund took upon itself to operate a mother and child station. Operation hours ranged from 8 hours daily in large camps such as Tira that housed 650 families, to only twelve hours a week in smaller maabarot such as Migdal-Gad that had only 260 families. In other maabarot a mobile clinic visited several times a week, or according to need. The medical supervision of Tipat Chalav services remained solely in the hands of the Ministry of Health. When it became necessary to expand the service in a particular maabara, the ministry turned to Kupat Holim requesting that the sick fund add hours or open a permanent station if the maabara had been ser-
duced by a mobile unit. Cooperation with the Ministry of Health in opening new stations or expanding existing ones was required since the ministry was the agency underwriting the service. Thus, Kupat Holim opened twenty new Tipat Chalav stations in November-December 1950, while Hadassah opened twenty-two new stations in January 1951. Most of Hadassah’s mother-and-child stations, however, were in the Jerusalem vicinity and in new urban centers—in the towns of Beer Sheva, Tiberias and Afula—while Kupat Holim, by contrast, operated stations throughout the country. There was no competition between Hadassah and Kupat Holim over mother-and-child station territory, and, in fact, in a number of cases there was even discussion of collaboration between the two organizations particularly in regard to staffing matters. In addition, the Ministry of Health requested that Kupat Holim serve as a supervisory proxy for the ministry in places where the ministry could not supervise operations. Thus, for instance, the Ministry of Health requested that Kupat Holim take upon itself the medical supervision of Hadassah’s Tipat Chalav in the Eliyashiv maabara where three hundred Yemenite immigrant families were houses.

Our suggestion is: A. That your pediatrician in the district, Dr. Sternovsky who is already visiting the station, will continue these visits (once-a-week visits) and include also supervision of the school, the kindergarten and the little infant house on site. B. that the gynecologist from your maternity hospital in Hadera visit the station for pregnant women once every three weeks. Please inform us of your agreement to this setup which will advance welcome cooperation between the institutions dealing with preventive medicine in immigrant housing, and will even be important in including the hospitals within the framework of preventive medicine.

The depth of Kupat Holim’s involvement in local health matters in the maabarot hinged to a large extent on local initiatives. In a number of maabarot, Kupat Holim staff agreed to take upon themselves the supervisory functions of schools and educational work in preventive medicine, without any remuneration. In other places, Kupat Holim staff limited their focus to serving only members of the Federation of Labor, leading to complaints that the sick fund “refuses to take care of hygiene matters in the general school, claiming that the sick fund only provides assistance to members of the federation. In this way, the school is left all the time without sanitation and hygiene supervision, even if the situation in the maabara calls for this.” A similar complaint was registered against Hadassah which refused to budget a regular nurse in the school. Generally, local residents were not interested that supervision of educational institutions was officially the responsibility of the Ministry of Health, not Kupat Holim. In their perspective Kupat Holim or Hadassah were the only agent’s responsible for their health—for better for worse, and their complaints reflected this perspective. Kupat Holim’s
explanations that this was not their duty did not convince the locals that the sick fund was acting correctly.

The Ministry of Health apparently served as the only coordinator between Hadassah and Kupat Holim, for there is no evidence of direct correspondence between the two organizations to be found. At the close of 1952, Hadassah transferred to the Ministry of Health all the mother-and-child stations it had operated. Thus, mother and child stations in the maabarot remained at the same time, in the hands of Kupat Holim and the Ministry, dividing between them the work according to areas agreed upon in advance. The regional allocation between the sick fund and the ministry in running mother and child stations continued even after residents of the maabarot began to move into permanent immigrant apartment blocks. Thus, Kupat Holim was requested to open Tipat Chalav stations and provide preventive medicine services in new immigrant neighborhoods that began to be constructed in development towns including Yokneam, Atlit, Tira, Givat Olga, and Kfar Yona, and in veteran communities including Rechovot and Gedera that absorbed immigrants. The ministry underwrote the programs and supervised them.

**Health Politics in the Maabarot**

In October 1950, Ben-Gurion announced his resignation as head of the government. His resignation was designed to enable addition of another minister to the government—the minister of industry (in place of the Minister of Finance Kaplan who had held the industry portfolio temporarily). Appointment of a separate minister of industry was designed primarily to formulate national strategy that would bolster the country’s economy. But the addition of another minister to the coalition government had political ramifications—challenging the existing delicate balance between coalition partners within the government. The appointment had to be acceptable to all the parties and not all were in agreement. The primary opponent of this move was the religious bloc. Ben-Gurion had to resign and threaten new elections to pressure the religious bloc to give in. A new government was formed with thirteen ministers in the cabinet, and on November 1, 1950, the second government took office. Yaakov Geri was appointed minister of trade and Industry. The Ministry of Health, as well as the Interior and Postal Services portfolios, was again placed in the hands of a member of the religious bloc. As under the first government, Shapira held three portfolios and again there was no full-time health minister. Moreover, Shapira’s energies were focused on running Interior, while Health was viewed as a political extra designed to maintain the fine balance within the coalition.50

The political crisis in the middle of establishing the maabarot did not impact directly on the course of events, but indirectly influenced both the
public and the Knesset. The crisis demonstrated just how fragile the government was, while events—dealing with mass immigration and the ongoing influx of more and more destitute refugees—called for prompt and bold moves by a firm and united government that simply was not to be found.

The Ministry of Health ‘Putsch’

In the midst of the coalition crisis within the government, an internal crisis within the Ministry of Health broke out totally independent of the political crisis. Director-general Meir resigned after an extended battle with senior civil servants and department heads within his ministry and with representatives of the physicians in public service. Most of the Ministry personnel’s complaints focused on Dr. Meir’s centralized management. Ministry employees claimed that Meir’s management style limited their ability to function and undermined their work with immigrants in the camps and in the maabarot in particular. Furthermore, they charged that Dr. Meir was driven by considerations that were not in the best interests of the ministry: They claimed that Meir failed to use his authority to keep Kupat Holim in line when this was required; allowed the sick fund to enjoy a favored position in establishment of new services; and in general put the sick funds’ interests above those of the Ministry of Health; and refrained from working towards fair pay for government doctors whose wages were below those of Kupat Holim doctors. The physicians also cited Dr. Meir’s opposition to permitting doctors in public service to engage in private practice on the side, and Meir’s harsh criticism of doctors at the Tel Hashomer Hospital (mostly, doctors serving in the IDF) who were engaging in private practice—an unresolved issue that had been the subject of a bitter struggle between the doctors and the Yishuv’s public health institutions even before the establishment of the state.51

The senior servants’ revolt against Dr. Meir was brought up in the cabinet. Ben-Gurion’s attempts to reach a compromise between the sides and prevent Dr. Meir’s resignation failed. Dr. Meir was offended by the fact that the ministerial committee appointed to investigate the roots of the conflict failed to give him unreserved backing, and Meir preferred to resign. The Ministry of Health was left without a director-general at a critical juncture for the state—all the more critical since the ministry had only a part-time minister which further expanded the role of the director-general as the chief policy-maker.52

The resignation of Dr. Meir brought collaboration between the Ministry of Health and Kupat Holim to an end. Yet, it should be noted that during Meir’s tenure, even when there were clashes between the sides, in general disagreements were settled by a compromise with which both sides could live, or at least to the satisfaction of Kupat Holim. The senior servants in the
ministry charged that, in fact, decisions *always* were taken in the interest of Kupat Holim, and cooperation was merely for appearance sake. Under the surface, the bitterness felt by ministry personnel built up until it broke forth with full force. Yet, examination of ongoing correspondence of the ministry with Kupat Holim regarding health services in the maabarot reveals that the general atmosphere was not as bad as ministry personnel described it. The overriding attitude of onsite personnel was that problems should be solved practically and as realities dictated, refraining from getting involved in political clashes or competing for power bases.

Nevertheless, the entry of Dr. Chaim Sheba as director-general of the Ministry of Health in November 1950 brought a complete turnabout in interpersonal relations. On one hand, Sheba succeeded in ending labor unrest within the ministry by inaugurating full cooperation with his department heads and even heading a struggle to raise the salaries of government physicians, as they requested. On the other hand, his appointment again raised the old animosities and conflicting visions of the face of health services in the state, between Sheba and Kupat Holim.

Upon accepting the appointment, Sheba wrote to a friend,

Soroka was very angry that the doctors in the Ministry brought about this development, the resignation of the former manager of the Ministry of Health, Dr. Meir . . . If the doctors did everything in the proper manner or not—I don’t know. But they called this a putsch and they say they forced Meir to resign, or they forced the Minister of Health and the Prime Minister to request Dr. Meir to leave, because there began to be differences of opinion whether the Minister of Health should stand on its own and create tools in order to give service to mass immigration or that the Ministry of Health should be a branch of Kupat Holim.\(^53\)

Dr. Meir, for his part, preferred not to reply to the charge. In a summary report on the state of the Ministry of Health that he wrote following his resignation, Meir devoted only a few lines to the matter:

On the contrived revolt of 4 wing managers in the Ministry of Health, on the unbridled incitement carried out against me with the knowledge of the Minister of Health and the form, how matters were ‘managed’ over four months—I refrain from providing details. The matter was clarified in the special government committee by the Prime Minister, the Minister of Finance and the Minister of Health, and not I, I am surely too subjective in this matter, to have the last word. I cannot but note that had the Minister of Health known or had he desired more objectivity, things would not have reached the point of inflation of matters, the staging of a resignation and such a morass that was organized intentionally from the start.\(^54\)

Sheba knew his agreement to take the place of Dr. Meir would be coldly received by Kupat Holim, and even noted this openly:
I wrote all the comrades who approached me, that I have already gotten a taste of going for a position without the consent of Kupat Holim’s directorate and I don’t see the backing that I’ll receive, in order that I will be able to establish a Ministry of Health free of foreseeable pressure, and that pressures can be expected, this I became aware of from a meeting with Mr. Soroka. . . . If I’ll be a good boy—I’ll get help. If I won’t be a good boy—it won’t go.55

Sheba, as could be expected, had his own opinions as to the proper role of the Ministry of Health and the future face of the Israeli health system. He had already expressed his views early in 1948 with the establishment of the MS. Kupat Holim’s directorate feared for the future of the sick fund within the state, and therefore Sheba’s views were hardly viewed with favor. This placed the sick fund’s leaders and Sheba at loggerheads, each side convinced that its vision for the health system was the best for the country as a whole and for the immigrants in particular.

“Sheba hoped that the Ministry of Health would be allowed to establish its own services and enterprises in order not to have to stand like a pauper at the door and request serves from others, thus would be created the possibility of merging medical services into a single State service, of which the Military Medical Service would be a branch.”56

The appointment of Sheba changed both the general atmosphere and the balance of power between the Ministry of Health and Kupat Holim—including the question of medical care in the maabarot. In Sheba’s mind, most medical care should be transferred to the military, with the Ministry of Health supervising this work, since only they had the power to grapple successfully with overall organization and medical services on such a large scale.

Sheba’s appraisal was driven home by facts on the ground—the physical degeneration of the situation in the maabarot and the impact of the weather.

‘Operation Maabarot’

The fall season of 1950 brought stormy weather. Tents collapsed and wooden prefabs were damaged, and the maabara program encountered countless problems. Housing was not ready on time although waves of immigrants continued to enter the country without almost any limitations due to political conditions in their countries of origin. All this came on top of the usual problems of shortage of cash and personnel that prevented completion of the task before the onset of the rainy season. The government was forced, at Sheba’s recommendation, to order the army into the maabarot.

In November 1950, the IDF announced preparations for a special campaign—“Operation Maabarot”—parallel to the government emergency
program designed to provide a “roof over the heads” of children in the maabarot, Kupat Holim’s directorate feared that its image would be damaged and that the entrance of the IDF into the camps would be interpreted by the public as an admission of the sick fund’s inability to provide suitable medical services in the maabarot. It responded immediately, disseminating a press release stating that “Kupat Holim is responsible for most of the medical care in the maabarot” stressing that within six months the sick fund had taken over responsibility for 108 maabarot and working villages whose population encompassed sixty thousand persons. The executive also underscored that only twenty out of 108 maabarot had been turned over to the army’s care, and in only seventeen had Kupat Holim clinics been temporarily turned over to the IDF.57

On November 17, 1950, Colonel Yaakov Prolov, head of the IDF operations department published the details of orders for “Operation Maabarot.” The operational order was classified “urgent-confidential” and was disseminated to various Jewish Agency departments, the director-general of the Ministry of Defense, the prime minister’s military secretary and the Israeli Police Force. The order was also sent to all IDF units scheduled to participate in the operation. Kupat Holim was not among the recipients, even though it was scheduled to partake in the program.58 The order spoke of fifty-six maabarot, thirty-seven where situation was particularly dire, and more than fifty-two working villages and permanent settlements where immigrants had been settled.

The operation orders stipulated that the army would take over full responsibility for thirty-seven maabarot in difficult straits, organizing and maintaining sanitation and preventive medicine, information dissemination, care for facilities, disinfecting immigrants with DDT dust, hygienic supervision, regular check-ups, erection of sick rooms for hospitalizing serious cases, visits by doctor squads, care in children’s institutions including medical supervision and collaboration with government hospitalization facilities, as needed.

Primary care (in clinics) in most of the maabarot where the situation was fair was assigned to Kupat Holim. In maabarot where the situation was worse, the ones whose entire administration was turned over to the army, it was stipulated that the sick fund’s medical teams would continue to provide medical services as in the past, but would be subordinate to the maabara commander’s orders. Daily food supplies to local general stores remained in the hands of the Federation of Labor’s supply network—Hamashbir Hamerkazi. Tipat Chalav services were shared by the Ministry of Health, Hadassah and Kupat Holim. Eight hundred hospital beds in the camps and the maabarot remained the responsibility of the Immigrant Medical Service and the Ministry of Health.

The primary reason for Operation Maabarot was cited in the order itself, the title of which was, “The Mission—Assistance to Maabarot in the Winter
Period.” The primary goal was to prevent flooding, leaks in housing blocks, collapse of tents or huts, and cutoff of access to maabarot that would disrupt ongoing supplies to immigrants. Activity in maabarot that were deemed to be in peril of collapse into chaos, focused on engineering and organizational work at the camp level, and assistance to individual immigrants in distress on the individual level.

In December the budget for Operation Maabarot was set, particularly allocation of the fiscal burden. In the first stage, the cost of the entire operation was estimated to be 375,000 Israeli Pounds. Immediate health expenditures were estimated to be 10,000 Israeli pounds; Kupat Holim was called upon to cover 25 percent while the remainder was laid on the Ministry of Health. Hadassah was not mentioned in the operation’s program. The Immigrant Medical Service was not mentioned at all. The primary outlay was for engineering work and personnel—mostly IDF reservists, including two hundred doctors called up for active reserve duty. The maabarot were divided up among the IDF’s three regional commands (Northern, Central, and Southern Command) by geographical area. Medical responsibility was placed in the hands of the medical corps. Maabarot were also given to the Air Force and the Navy, following special requests from these branches that they be allowed to take part in the operation.59,60

**Drafting Doctors for the Maabarot**

On December 1, 1950, Operation Maabarot was officially launched. While the army had already been active in the maabarot, it was deemed necessary to officially declare the operation, both as a matter of public awareness, and for record-keeping, budgeting and organization. On December 18, the Ministry of Labor announced compulsory draft of physicians under the Emergency Regulations for Mobilization of Manpower–1948.

The announcement on compulsory mobilization of doctors was a matter of great concern within Kupat Holim. First of all, the sick fund had not been party to the decision. Present at the decisive meeting were the commander of the medical corps, representatives of the Ministries of Health and Labor, and two representatives of the medical federation. Dr. Lotan, the Ministry of Labor representative, was the unofficial representative of Kupat Holim, since he has deliberated with the sick fund on the issue several weeks prior and therefore was assumed to know the sick fund leadership’s position. Dr. Sheba and Dr. Lotan saw no problem in orders to draft doctors from the sick fund’s perspective. Dr. Sheba even stressed in discussion that in his opinion, Kupat Holim would be the chief consumer of the services provided by mobilized doctors and there was the assumption that Kupat Holim would, logically, unconditionally support the measure.61
Dr. Lotan sufficed with citing the fact that Kupat Holim urgently needed thirty doctors and would be willing to employ in its maabara clinics doctors drafted by the Ministry of Labor. Lotan did not relate to the mobilization of Kupat Holim doctors to active reserve duty, a critical issue from the standpoint of the sick fund. The decision was taken without Kupat Holim having the opportunity to present its position and without any joint discussion of the issue between Kupat Holim, and the Ministry of Health and medical corps before voting on the mobilization order.

Subsequently, Kupat Holim’s directorate immediately appealed the wording of the decision adopted regarding the doctors’ draft although in principle it supported mobilization of doctors and had even demanded such a move months prior. On January 1, 1951, less than two weeks after the announcement of a compulsory draft for physicians, Kupat Holim’s directorate initiated a meeting in the minister of health’s office to discuss again how to mobilize the doctors. Participating in the meeting were Minister of Health Shapira and Dr. Sheba, Eliezer Peri, the representative of Kupat Holim’s directorate, and Dr. Tova Berman, the medical director of the sick fund. Soroka was not at the meeting. One of the sick fund’s key arguments was that the announcement was too general, was not egalitarian, for it exempted in advance immigrant doctors. Moreover, it would enable many private practitioners to dodge being drafted and ultimately place the entire burden of mobilization on public institutions, first and foremost on Kupat Holim. Moreover, the sick fund argued that the period of mobilization, two to six weeks, was too short and would not answer the genuine needs of the clinics in rural villages and maabarot. The sick fund suggested, in addition to a compulsory doctors’ draft, that newly-licensed doctors be required to serve two years in a rural settlement or a maabara as a proviso to receipt of a license to practice medicine. As for nurses, although the shortage of nurses was greater than the shortage of doctors, the Kupat Holim directorate demanded that mobilization of sick fund nurses be cancelled, since all were already engaged in vital jobs, whether in hospitals or in maabarot, and it was impossible to surrender even one of them.

Dr. Sheba objected to the sick funds’ demands and its suggestion that the draft regulation be changed to create a more egalitarian sharing of the burden. In his view, working in a village did not have to be a proviso forced upon immigrant doctors in exchange for a license to practice medicine because the immigrant doctors were not skilled enough for such work. He also argued that mobilization of veteran physicians and specialists was what was really needed—individuals whom Sheba believed were capable of providing a real contribution and improving the situation in particularly distressed points of settlement. Most of the veteran specialists were in Kupat Holim, and it was their mobilization that the sick fund feared the most. In the end, the discussion ended without any progress. The compulsory draft
remained as drafted, and the only promise the minister of health made to the sick fund was that if the mobilization was not carried out as planned, the issue would be re-discussed.

The shortage of medical staff in the private market—paradoxical as there was a surplus of doctors in the city—and a serious shortage of doctors in rural areas, especially in maabarot and in the public service on the whole, was discussed a number of times in the Knesset and was the focus of debate between representatives of the doctor community, and heads of the public health system. Most of all, the doctors wanted to prevent legislation that would coerce them to work according to the needs of society and sought to preserve their organizational and professional independence. By contrast, members of the public health system sought to initiate legislation that would force young doctors and doctors with vital specialties to invest some of their time in service to the public. Because the legislative process designed to regulate the work of physicians in the country and to attract or to push physicians to work in rural villages was a slow business, a compulsory draft for short periods under the force of the country’s emergency regulations was the only solution. The IDF medical corps which bore most of the responsibility for Operation Maabarot, supported this strategy. Another supporter was Dr. Sheba, the director-general of the Ministry of Health, who much earlier had held that demands should be made on medical experts to fulfill a certain quota of service to the public, even without hinging licensing on mobilization and without forcing young doctors to serve in the periphery before finishing their training.

Declaration of compulsory mobilization of doctors by the government required the Israeli Medical Federation (IMF) to take a stand on the issue. For months the IMF had been struggling to establish its position as the dominant voice and even sole representative of the doctor public in the country, seeking to prevent establishment of a Federation of Labor organization that would represent only physicians in public service or only Kupat Holim physicians. In addition, they sought to bring the new doctor sector that had emerged—government doctors, under the authority of the IMF. It was clear to the leaders of the IMF that they must change their orientation, and depart from their traditional stand. In the past, the IMF had opposed any form of compulsory draft. It argued that mobilization of this sort primarily assisted Kupat Holim, allowing the sick fund to bring doctors into its ranks, employing them on a temporary basis through the Ministry of Labor without any of the professional and social commitments entailed in regular employer-employee relationships. Now, in an unusual move, the doctors’ professional organization announced that the IMF supported compulsory mobilization of doctors to serve in the maabarot, and added that the IMF’s own leadership would be the first to volunteer to serve.62 The surprise announcement thrust the doctors’ professional organization into the forefront as an organization ready
to assume social responsibility by placing the needs of the country above all other considerations in its readiness to fully cooperate with the government in an urgent national endeavor. By placing the doctors’ professional organization and the government in the same camp, it pushed to the side criticism of the IMF from Ministry and Kupat Holim quarters in the previous year during the struggle over professional representation of the doctor community. While it may be that in the long run the IMF hoped its support would be translated into political clout—recognition of the organization as the sole representative of the doctor community in the country, the organization’s unequivocal stand committed doctor members be drafted who in the past had not considered it their duty to come to the aid of the maabarot—now, out of commitment to their professional organization and to maintain the IMF’s credibility and stature in the eyes of the public. Facts on the ground, however, were less positive and the honeymoon was short lived.

In March 1950, four months after the Ministry of Labor announced compulsory mobilization of doctors, it became evident that Sheba’s appraisal had been wrong, and Kupat Holim’s had been correct. In practice, many of the civilian doctors drafted for short periods succeeded in dodging service in villages and maabarot. As a result, in April, the government announced it was raising the age for mobilization to fifty-five. This move, however, did not significantly change the situation and even sparked anger within the IMF. Thus, after a short hiatus of collaboration with public institutions, the IMF was again at loggerheads with government authorities and the public medical system as a whole, this time over the status of doctors and the remuneration they would receive for their work in various capacities.

The shortage of medical personnel in Kupat Holim’s services in the maabarot was so severe that Mordechi Namir, chairperson of the Federation of Labor executive’s coordinating committee, threatened in an April 1951 telegram sent to Prime Minister Ben-Gurion that Kupat Holim would suspend its services to immigrants, because monies promised the sick fund had not been forthcoming, but mainly due to the shortage of personnel that made it impossible for Kupat Holim to function. Namir demanded immediate government assistance and demanded that the draft period for doctors be extended to prevent the total collapse of Kupat Holim. Similar warnings were published in the press, including the reason for the dire state of the sick fund and the demands from the government.

The tension between the sick fund and the public system brought the issue to the prime minister’s office, as well. In July of the same year, Prime Minister Ben-Gurion met with representatives of the medical federation to discuss a suitable solution to the shortage of personnel in Kupat Holim. The IMF representatives, Dr. Avigdori and Dr. Druyan, told Ben-Gurion that continued compulsory mobilization of doctors and the sick fund’s demands under prevailing circumstances was a wasted effort, of no utility. Dr. Avigdori argued that since
the number of doctors promised to Kupat Holim was similar to the number of doctors in the sick fund of draft age, only a handful of doctors would be added to Kupat Holim staff. Moreover, according to the notes of the meeting in Ben-Gurion’s diary Avigdori also claimed that “physicians work in the army is not economical. A doctor doesn’t work more than two hours a day. . . . as a doctor. The doctor doesn’t have a vehicle that would allow him to move from place to place. Sits in place and his work is meager. In Imperial Germany there were 300 doctors for 100,000 soldiers. Here the doctors engage in [military] exercises. With the doctor shortage this is unnecessary. There’s wastage of manpower.” In his summary of the meeting with the doctors, Ben-Gurion said,

Avigdori suggests a committee to clarify the need for doctors. Avigdori also disagrees with the army’s assumption that the best doctors will be sent to the army, the weaker ones to the maabarot. The opposite. The army has healthy boys, in the maabarot are the weak. Since the establishment of the state, 1,200 doctors immigrated to Israel. This number should be enough for immigration (600,000 immigrants). Everywhere in the world this is enough. . . . Atzmon [SS the Chief Medical Officer] denies that military doctors work 1–2 hours. The opposite. [They] work more than anywhere else, 12 hours a day, expect for places in the Arava. There are also civilian doctors in the army—51. . . . in reserves. The budget, the staffing strength is very small.63

Despite Ben-Gurion’s personal involvement, no solution emerged from the meeting. The IMF refused to continue to cooperate, and Kupat Holim did not receive additional doctors beyond the first draft. The shortage of medical personnel in the maabarot remained unchanged.

In March 1951 Operation Maabarot officially came to a close. The order, signed by the chief of operations, Yitzhak Rabin, stated,

In accordance with clause 2D in its above letter, Kupat Holim is prepared to take over care for the maabarot that remain in the medical care of the IDF beginning July 1, 1951. . . . Departure of the army medical squads will take place only after the entrance of Kupat Holim’s medical personnel to each maabara. . . . The Chief Medical Officer Command will attend to coordination between the Kupat Holim directorate and the Southern Command.64

Despite clear orders, there was no coordination, and transfer of authority from the IDF to Kupat Holim did not go as planned. According to reports sent by Dr. Tova Berman to members of the sick fund’s directorate and to government ministries who had been involved in the campaign, most of the military physicians left before the arrival of their replacements. In other cases, doctors from Negev settlements and maabarot were drafted into regular military service and the settlements were left without a doctor. Dr. Berman stressed that “drafting into conscript service and for academic deferments also decimates
our work.” To reinforce her complaints she brought nine examples where a
doctor in a maabara or a new immigrant moshav settlement had been drafted,
leaving an entire group of settlements without medical assistance. As a result,
Kupat Holim doctors caring for new immigrant villages in the Negev had to
take care of a larger number of settlements. For example, the doctor at Kib-
butz Saad was responsible for eight other settlements, while the maabarot Zar-
noga, Migdal-Gad, Beer Sheva and Yavneh remained without even one doctor
after all the doctors in these isolated settlements were drafted. She also cited
the case of the Nes Tziona doctor who had to be sent to Eilat—leaving the
immigrant neighborhood where he had worked without a doctor.65

Despite Dr. Berman’s criticism, leveled primarily at the Medical Corps and
drafting policies for doctors, the army’s Maabarot Campaign was a success,
particularly from a logistics standpoint. The establishment of orderly organi-
zation by the army enabled the maabarot to begin to function as immigrant
housing projects. As a result of the army’s successes in the winter of 1950,
when similar needs arose after more maabarot were established, the army
again stepped forward to renew Operation Maabarot.

At the beginning of August 1950, the IDF was again mobilized to assist in
the maabarot. The new mission orders, classified “urgent-secret,” read,

Mass immigration as planned in advance, has confronted the Absorption
Department of the Jewish Agency with severe problems that it cannot solve
through its permanent machinery . . . As a result, the maabarot are in a bad
sanitary state and a dissonant public atmosphere. In addition there is a severe
shortage of suitable personnel to operate those facilities established in the
maabarot. The army is needed to go into a number of maabarot and take their
organization upon itself.

Clause 7 of the order was entitled “Medical Care” and stated that “medical
care is given in all maabarot through the auspices of Kupat Holim. The army
will assist in bolstering professional staff—primarily medics.”66 This time
few doctors were drafted for the operation, and little was accomplished in
improving the staffing problems of the sick fund. Shortage of medical per-
sonnel in the maabarot continued to be the key weakness of Kupat Holim’s
operation among immigrants—not only in the maabarot but, in essence,
throughout the entire period of mass immigration.

In November 1951, a few months after the official close of the first
Operation Maabarot, and at the close of the second mini-operation, Sheba
released a report detailing the breakdown of draftees among the doctor
public. Thirty-nine percent were doctors from private practices, 11 percent
were physicians employed by municipal bodies, 6 percent were employees
of other sick funds, ten percent were government employees and thirty-four
percent were Kupat Holim doctors. According to Sheba’s records, a total
of approximately 500 doctors who were draft age were sent for service on the frontier, primarily at the request of Kupat Holim; eighty of them were Kupat Holim doctors. In the end, only forty-five doctors out of all those drafted were sent to the maabarot. The doctor community in the country, with the exception of Kupat Holim, mustered only one-hundred-sixty doctors—twenty-four of them government doctors although there were approximately three thousand state-employed doctors at the time.67

In Sheba’s eyes, the doctor draft was a success, and he even requested that his report be read in the sum-up meeting of the Federation of Labor executive. In the eyes of Kupat Holim, the drafting campaign had been a failure—an additional burden in addition to the ongoing responsibilities of the sick fund in the maabarot. While the draft, which the sick fund’s management could not enforce on its own, coerced a number of the sick fund’s specialists to go out to serve in villages, every drafted doctor from urban clinics or Kupat Holim hospitals increased the already existing pressures at these service points. Thus, in the last analysis, Kupat Holim didn’t receive any significant assistance from the doctor draft for the maabarot.

One of the difficult aspects of the shortage of medical staff in the maabarot clinics that prevented continuous supply of medical services to immigrants was the increase in violence against health agents in the maabarot—whom the resident population viewed as responsible for their distress. As a result of the rise in attacks by immigrants on physicians (and their families who lived nearby), the Kupat Holim directorate wrote the Jewish Agency that

There is no possibility of maintaining a clinic and serving the population there with medical assistance in places such as this. The doctors and the other workers are under the pressure of constant terror. The patients dictate to the doctors the medical certificates regarding their ability to work, in regard to insurance, in regard to medication and illness, and so forth. Every impartial refusal is met with unruliness and [physical] blows. The police onsite tried to do something, but either its force is limited or too tired. . . . If the police won’t know how to enforce order, there will not be any doctors worthy of their title that will be willing to work under such conditions, and even today, in practice I can’t find suitable personnel for this maabara.68

An attached appendix to the letter contained specific cases of violence in the Ramat Hasharon maabara—with the names of the violent immigrants who were labeled “genuinely [from] the underworld.” The Kupat Holim directorate underscored that it was not a matter of isolated incidents, or only the Ramat Hasharon maabara, but rather a phenomena that existed in many other places. The sick fund called upon the Jewish Agency to act. Otherwise, the sick fund would suspend its services at such sites.

It should be kept in mind that violence in the maabarot was evidenced in other areas, other than health—in education, welfare, social benefits—
reflecting the desperate circumstances of immigrants, who in many cases merely sought to force the ‘system’ to provide them with the services they needed.

It is important to underscore that the shortage of medical personnel was part of a general shortage of services in the Israeli social system. There was also an acute shortage of teachers, social workers, and other personnel. Few were willing to work in the maabarot, even on a temporary footing. There were also serious problems in mobilizing skilled personnel to deal with immigrants suffering from an inability to cope, disabilities, and mental illness. In some cases, where possible, the government trained new immigrants to staff social services that could not be filled. Thus, for instance, new arrivals with suitable scholastic backgrounds were trained in short intensive courses to serve as social workers and other supportive functions in the maabarot and in the welfare services.\(^9\)

The Ministry of Health and Kupat Holim—
Relationships during the Maabarot Period

The tensions surrounding the acute shortage of personnel and endless disagreements over drafting of doctors, whether for the army or the maabarot, impacted on already tense relationships between the Ministry of Health and the Kupat Holim management—particularly Dr. Sheba’s attitude towards Soroka and Dr. Berman. Sheba was personally insulted by the sick fund’s criticism of the ministry’s performance in dealing with mass immigration—whether in the media (primarily the Mapai party daily, Davar), whether in internal sick fund publications that fell into the hands of the Ministry. Sheba took the criticism personally, and responded accordingly.\(^9\) The handful of letters that Sheba wrote to Soroka and Dr. Berman were penned in a tone that clearly reflected his stormy frame of mind. Soroka, Dr. Berman and others replied in kind. The tension between the two bodies was paralleled by disagreements regarding legislation of a compulsory health insurance law within the framework of social insurance, and the political barriers that the Progressive and General Zionist parties, or the IMF itself sought to establish to undermine such legislation. Correspondence between Kupat Holim and the ministry over provision of medical services to the maabarot and immigrant settlements became intense and quarrelsome, marked by mutual accusations with each side criticizing the other’s performance and accusing the other of responsibility for the situation. The ministry sent tens of letters to Kupat Holim complaining that the sick fund was not providing the health care it promised, accusing the sick fund of dragging its feet in opening clinics, charging that the sick fund was responsible for the shortage of nurses, caretakers and medics, bottlenecks in hospitalization and so forth.
There were accusations from both quarters surrounding the shortage of hospitalization facilities of children. Kupat Holim protested Tel Hashomer Hospital’s refusal to admit children that the sick fund referred for hospitalization, although Kupat Holim believed there were empty beds available, while the ministry protested the fact that the sick fund was sending children for hospitalization in facilities that were not designated for pediatric care. Both sides habitually argued that the right of the maabarot children to receive care should take preference over other children, but in practice, every case rekindled the dispute over who was responsible for providing the service, who would pay for the service and who was at fault when treatment was delayed. The Ministry of Health demanded that the sick fund provide services that were not set forth under its arrangement with the government, such as hygiene in the schools or kindergartens in the maabarot, and when Kupat Holim refused to do so for lack of staff, or requested extra funding for the service, the Ministry of Health’s response was very harsh. Because the Ministry of Labor, under the leadership of Minister Golda Myerson (Meir) was partially responsible for organizing services through the labor of draftees, the Kupat Holim directorate often referred requests and complaints to the Minister of Labor who then referred them to the Ministry of Health. The absence of a direct line of communication between the sick fund and the ministry generated a lot of anger and counter charges from within the Ministry of Health which did not look fondly on involving the Ministry of Labor in their affairs. They viewed labor’s intervention as a conscious attempt to sully the image of their ministry and to skirt the sick fund’s responsibility, particularly because Golda Myerson, they charged, always sided with Kupat Holim whenever she was asked to intervene. For example, Dr. Jenny Taustein wrote the Kupat Holim directorate:

Dr. Lehrman from the Ministry of Labor transferred to us several months ago the report of a Kupat Holim physician from the Judea District on the situation of infants and children in Moshav Zavdiel and requested that we visit onsite and suggestions for improving the situation. This visit was carried out by us and we summed up the visit in a report that we handed over to Dr. Lotan [SS the Ministry of Labor] to whom the Kupat Holim request was addressed rather than to us. . . . Our visit in Zavdiel did not clear up for us [why] the alert to the Ministry of Labor by Kupat Holim, when most of the rectification of the situation is intensification of medical work that is in the hands of Kupat Holim, and not in the hands of the Ministry of Labor.71

The news media as well frequently and prominently dealt the struggle between Kupat Holim and the Ministry of Health over health services in the maabarot. For instance, articles were published with headlines such as “A Journey in the Kingdom of the Struggle Over Health,” and “Doctors Attack Agencies Regarding Health Absorption of Immigrants.” In any case, the tension between Kupat Holim and the Ministry of Health hardly contributed to the “health” of health services.
In October 1951, Dr. Sheba resigned as director-general of the Ministry of Health, but agreed at the personal request of Ben-Gurion, to stay on until a new Minister of Health took office or until a replacement for him could be found. Kupat Holim immediately recommended Dr. Abeles, a sick fund doctor, for the position, but as the bitter political crisis within the government over establishment of a state-run educational system worsened, no decision was taken on the matter. Dr. Sheba’s resignation was a protest fueled by continuing discrimination in the wages and working conditions of Ministry of Health employees compared to Kupat Holim employees, but the move was also a protest against delay in social legislation that Sheba felt would free the health system from the control of Kupat Holim—control that in Sheba’s mind was the root of most of the health system’s problems.

When I was called upon against my will to go in and manage the Ministry of Health, I brought the Kupat Holim directorate—with its say-so and control of the purse strings, as a decisive argument for my reluctance [to take the post], for I feared that should I not be willing to do the bidding of this body, I will be a target of slander by the regular routine. Not under any conditions or promise of protection am I prepared to continue the empty controversy on the pages of the press with an institution that has its own private paper and own public paper for smearing another person and praising itself, nor [will I] cause the downfall of the government in whose name I operate.72

It was evident to Ben-Gurion as well that the tensions between Kupat Holim and the Ministry of Health were blocking any progress in providing for the maabarot and formulating general policy for the state. Following the meeting in which Sheba told Ben-Gurion of his desire to resign, Ben-Gurion wrote in his diary that “it is imperative to bring Kupat Holim’s operation into line with the needs of the state.”73

In November 1951, Kupat Holim’s 1952 budget was set at fourteen million Israeli pounds, while the Ministry of Health budget was set at only seven million pounds. In 1952, Kupat Holim’s budget almost doubled—twenty-one million pounds, while the budget of the Ministry of Health’s budget was only eight million pounds—one-and-a-half million of which was transferred to Kupat Holim for medical services it provided immigrants in the maabarot who were not members of Kupat Holim.74 Thus, it is no wonder that Sheba felt his ministry was placed in a greatly inferior position compared to Kupat Holim.

Kupat Holim towards the Close of the Period of Mass Immigration

In November 1951, Kupat Holim’s National Supervisory Committee convened a special meeting to pass a number of decisions regarding the relationship
between Kupat Holim and the state, and Kupat Holim and the Federation of Labor. Most of the discussion focused on formulation of a call for the government of Israel and the Ministry of Health to change the law regarding drafting doctors in a manner that would solve the chronic shortages of medical personnel. The supervisory committee requested that doctors serve in villages and maabarot, establishing a proviso that only a doctor who fulfilled this duty would receive a license to practice medicine; that the mobilization of nurses be made compulsory; and that a compulsory national service law be passed for veteran nurses and doctors for service in villages. Lastly, the supervisory committee demanded that the government of Israel “recognize legally that Kupat Holim is a vital institution with all the rights emanating from this.” The supervisory committee also addressed Kupat Holim’s relationship with the Federation of Labor. At the close of discussion it was decided to call upon the Federation of Labor’s executive to work towards advancing all the sick fund’s demands from the government; to attend to financial backing from government agencies for all Kupat Holim operations in the realm of investment in infrastructure and absorption; and to increase the sick fund’s budget from the joint tax. The supervisory committee’s point of departure and the foundation for its demands from the government and from the Federation of Labor was the assumption that the scope of immigration would continue as is, and the sick fund’s operations within the health system would continue as in the past, and even grow. But this was not the case.

At the outset of 1952 the scope of immigration to Israel dropped significantly. According to Yitzhak Rafael (director of the immigration department in the ministry within the Jewish Agency), various limitations on immigrants and immigration were behind the drop, discouraging more newcomers from coming. Others cite political changes in the countries of origin that either barred exit or made immediate immigration less attractive, while the reservoir of Jewish communities with immigration potential had largely been depleted during the first years of statehood. While the drastic reduction in the influx of newcomers reduced the overall percentage of immigrants living in maabarot, in practice the problem inside the maabarot multiplied: The strongest elements among the newcomers, those with the best coping skills, left the maabarot for immigrant neighborhoods or found permanent housing solutions and livelihoods in other frameworks, on their own. Thus those left in the maabarot were the weakest elements in terms of age, health status, employability and cultural acclimation. The maabarot rapidly became pockets of people marginalized by social disorientation and distress, rather than the stopgap shelters for which they were designed.

In mid-1952, realizing that the situation was changing and assuming that the maabarot would soon be dismantled, Kupat Holim saw that it would have to change its pattern of services and shift the focus of its work to immigrant neighborhoods and rural moshav settlements. Yet, the sick fund leadership
was aware that in the meantime they would have to continue to provide services to thousands of immigrants who remained in the maabarot, with all their serious health needs.

Kupat Holim annual reports on the scope of the sick fund’s operation in the maabarot and immigrant villages in the years 1952 and 1953 reveal that despite the drop in the scope of immigration and despite the need to open new clinics in immigrant neighborhoods, all the Kupat Holim clinics in the maabarot continued to function.

The geographic outreach of Kupat Holim encompassed 353 settlements, including maabarot and abandoned Arab villages now populated by Jews that had makeshift facilities or no previous infrastructure whatsoever. For instance the Judea District of Kupat Holim—a triangle between Tel Aviv, Jerusalem, and Rechovot—operated health clinics in seventy-three different points of settlement, including sixteen maabarot and abandoned villages. The district employed 157 general practitioners, 104 of them in the maabarot. In addition there were eight pediatricians and seven specialists (orthopedics, and so forth). By contrast with the scope of operations in new immigrant neighborhoods and clinics in the city—work in the maabarot was almost entirely in the hands of Kupat Holim. For instance in the Negev District where most of the immigrants were concentrated in new rural settlements, there had been only two active maabarot—in Beer Sheva and Eilat; Between 1950–52 Kupat Holim opened forty-one new clinics—a two-room clinic in every moshav. That year thirty-four general practitioners worked in shifts at the various clinics in the Negev District. In the Beer Sheva and Eilat maabarot new clinics were not opened; rather the inhabitants were served by existing clinics operating in the two towns. In Beer Sheva twelve doctors in Kupat Holim’s Central Clinic in the Gimel neighborhood served the adjacent maabara, and in Eilat, eight doctors working in the town provided medical care to the town’s maabara, as well. The clinics in the moshavim did not operate on a daily basis; the frequency of weekly schedules was adjusted to the size of the moshav population. There were some traveling doctors who served between five and eight different settlements. The major concentrations of maabarot where Kupat Holim still maintained clinics included the Judea District (in the vicinity of Rishon Le-Zion)—twenty-four maabarot and abandoned villages; the Sharon District (in the vicinity of Petach Tikva)—eleven maabarot and abandoned villages; the Shomron District (in the vicinity of Natanya)—8 maabarot. In the Jezreel Valley there were two maabarot clinics. In the Galilee (including the development town of Kiryat Shmona) the number of clinics between new rural moshav settlements (twenty-five clinics) was almost equal to the number to the clinics in twenty-nine maabarot and abandoned villages.77

The financial reports of the same year (1952–53) demonstrate that the sick fund’s expenditures didn’t really go down following the drop in immigration.
In fact, distribution of membership simply grew, requiring the sick fund to construct and staff a large number of new clinics. Fifty percent of the annual budget was earmarked for clinics, and 20 percent for hospital care. Administrative costs were extremely low—only 3 percent of the budget. In other words, most of the budget was earmarked for medical work in the field.

In 1952, Kupat Holim employed a total of 5,665 personnel serving about three quarters of a million members, including 1,257 doctors, 1,587 nurses, 233 dentists and their assistants, 220 pharmacists, 275 lab workers and technicians, 1,285 auxiliary staff, and only 908 administrative staff. The overwhelming majority of Kupat Holim’s income came from Federation of Labor sources—either federation dues (42 percent—the joint dues or employer participation in social benefits 37 percent—the parallel tax). The government’s direct funding of sick fund operations was a mere 8 percent of Kupat Holim’s total budget. In February 1952, the Federation of Labor employed 13,500 persons—40 percent of them in the sick fund (the others were in federation-owned industries). Not only was Kupat Holim the largest health institution in the country, it was also the Federation of Labor’s largest institution, and, in fact, one of the largest employers in the public sector as a whole. Despite the sick fund’s size and its almost all-pervasive scope of operation, Kupat Holim’s political stature was still not strong.

On December 19, 1952, Ben-Gurion resigned for the third time in four years. Five days later, a new government was formed—the fourth in the history of the State of Israel. Yosef Serlin, a member of the General Zionist Party, was appointed Minister of Health. Four days after the new coalition government was formed, Dr. Sheba requested to meet with Ben-Gurion and reiterated his desire to resign. Following his meeting with Sheba, Ben-Gurion wrote about the health issue in his diary in a manner that basically echoed the complaints Sheba had raised:

At the moment there are 4 health authorities in the state: the state, Malben, Kupat Holim, [local] Authorities (except for Hadassah). The Yishuv expends about 70 million on health, 14% of the [gross] national product, twice that in England. Plurality brings waste. Kupat Holim provides deluxe services to a portion of its members; most of the income not from members, but from the state, from the [United Jewish] Appeal, and employers. Soldiers’ families and civil servants insured with them, by the state. This is expensive. Preventive medicine shouldn’t be separate from curative care. The patient isn’t just an individual, but a family and society; Requires also merging the Medical Corps with the Ministry of Health. . . . I told him to reconsider. While now it will be harder to merge Kupat Holim with the state, but after the elections for the Federation [of Labor] it will be possible, and hearts should be won over. If he leaves, it will make things harder. Also possibly easier to collaborate between the state and between Malben, the [local] Authorities and the army when he will head the state service.
Ben-Gurion’s attitude towards Kupat Holim, as expressed in his diary, was nothing new. Ben-Gurion’s declarations that in the future Kupat Holim should be merged with the state had been hanging over the sick fund’s head like a Damoclean sword for years, and was a driving force behind the sick fund’s attempts to do everything in its power to reinforce its position and broaden its base of operation to a point of no return beyond which the state would be unable to nationalize Kupat Holim. It is clear from the entry in his diary that Ben-Gurion accepted Sheba’s picture of reality without cross-checking the facts as to the genuine scope of Kupat Holim’s operation or the sources of its funding. Half of Kupat Holim’s budget was from joint dues, in other words, from the Federation of Labor, not from the state as Ben-Gurion concluded—under Sheba’s influence. Most of the immigrants joined the Federation of Labor through their workplace, and federation dues were what underwrote the majority of the sick fund’s services. The State of Israel’s direct assistance to the sick fund in 1952 was a mere half a million Israel pounds budgeted to cover expansion of hospital beds in the sick fund’s hospitals. The exact same amount was given to other public hospitals so this was not something exclusive to Kupat Holim. The state’s participation as an employer in paying the parallel tax for civil servant’s health insurance constituted only 13.5 percent of Kupat Holim’s income. The Ministry of Health’s additional payment to the sick fund—for health services for immigrants who were not members of the Federation of Labor, was only half a million Israeli pounds, of twenty-one million budgeted by the fund that year. Therefore, it is hard to accept Ben-Gurion’s conclusion, as recorded in his diary, that the source of most of the sick fund’s budget was the state.

Ben-Gurion’s description of Kupat Holim’s services as “deluxe” was also unjust, and to a large extent simply echoed Sheba’s charges for years concerning the so-called “luxury” Kupat Holim had instituted in its hospitals. Every time this accusation was raised, Yitzhak Kanev and Moshe Soroka defended the quality of construction of Kupat Holim’s hospitals and central clinics, arguing that this was the sick fund’s deliberate policy, based on the assumption that quality construction in the long run would enable the sick fund to provide quality care, and ultimately would justify themselves economically since the buildings would serve Kupat Holim for years to come. In the final analysis, the outlay on quality would save maintenance costs and renovation farther down the road. Writing in an article published in May 1953 in Davar in response to but another attack on the sick fund, Kanev retorted, “Here’s but another sin to Kupat Holim’s account. Its hospitals are among the most sophisticated. Indeed, there are primitive hospitals in the country, yet we did not assume that as a result we are duty-bound to lower the standards of care in Kupat Holim hospitals.”

Sheba, and Ben-Gurion operating under Sheba’s influence, were in the habit of comparing the facilities at Tel Hashomer with those at nearby
Beilinson Hospital. Indeed, the differences were stark. The technical and structural condition under which Tel Hashomer operated, in old pre-World War II buildings including separate Quonset Huts, were Spartan, even substandard. But, jumping to the conclusion that hospitalization services of Kupat Holim were luxurious and that the benchmark should be Tel Hashomer had no objective or logical basis. In any case, comparisons of the sick fund’s hospitals, which for the most part were newly-constructed, with government hospitals which operated in decades-old buildings not designed for this purpose was raised in the press over and over, each time Kupat Holim dared to criticize government officials.

Ben-Gurion’s request that Sheba reconsider his decision to resign was to no avail. Several weeks after meeting with Ben-Gurion, Sheba submitted his official resignation and was replaced by Dr. Btesh, who until his appointment had been administrator of the state-run Yarkon Hospital and a civil servant. Kupat Holim had been unsuccessful in bringing about the appointment of one of its own people as director-general. Sheba’s resignation did not lower tensions between the ministry and Kupat Holim. Nor did the drop in the influx of immigrants that made the maabarot a less burning issue change the relationship between the two leading health agents in Israel. Ben-Gurion’s conclusion—that the state should attempt to transfer Kupat Holim into government hands provided enough fuel to keep tension high between the two.

In May 1953 the Knesset held a broad discussion of health issues in the State of Israel, in the framework of budget debates. The focus of deliberations was the multitude of problems providing health services for immigrants. Most of the charges of dysfunction within the health system were leveled at Kupat Holim. First and foremost among the accusers was the new minister of health, Yosef Serlin. Serlin’s complaints against the sick fund reiterated both the criticism and the solutions proffered by Serlin’s predecessor—that is, to transfer Kupat Holim into government hands. The attacks on the sick fund were prominently reported in the daily press: “The Minister of Health attacks Kupat Holim” (Davar); “The Minister of Health accuses Kupat Holim of Redundancy of Services” (Jerusalem Post); “The Minister of Health Attacks” (Al Hamishmar); and “The Minister of Health Demands from Kupat Holim” (Haboker). Yitzhak Kaney penned a strongly-worded article in response to the minister’s accusations and policy. He contradicted Serlin’s accusations in the Knesset, point by point, particularly regarding Kupat Holim’s work in the maabarot, leveling charges of his own against the government and the Ministry of Health.

The Minister of Health claimed in the Knesset that Kupat Holim opens clinics in points [of settlement] where the government is also opening its own clinics. This is the first time this claim is being heard. . . . Now let the Ministry
of Health reply: What are the points where they are willing to open clinics, except that Kupat Holim delays them? Where is the government establishing clinics that will also serve the insured population in Kupat Holim? In any case, Kupat Holim’s directorate is willing to discuss any concrete suggestion such as this out of good will for coordination and cooperation. The Minister of Health claims, relying on his advisors, that it would be correct to open clinics adjacent to hospitals. Such clinics already exist, and as experienced people we can say that this kind of clinic has the power to provide ambulatory assistance only to a tiny portion of the public. Hospitals are not able to absorb masses of ambulatory sick persons because the hospital medical personnel devote their operation primarily to the hospital. In most places of settlement there aren’t any hospitals, and in the cities there is no ability to concentrate sick people around the hospital particularly, and experience has taught us it is necessary to establish regional clinics. Is there substance to the proposal to refer the 10,000 callers daily at 24 Kupat Holim clinics in Tel Aviv to the municipal hospital in this city, as well as the thousands of callers at the clinics in Jaffa— to the government hospital? The existing clinics adjacent to the hospitals—by nature distinguish themselves in special expertise like central clinics and will only serve a limited number of inhabitants. Kupat Holim is experienced in ambulatory work and it examines all the methods that are feasible, and if hospital doctors are willing to serve as consultants in central or regional clinics, Kupat Holim is prepared to receive their services, with pleasure.

In 1953, Kupat Holim operated clinics in 164 immigrant moshav settlements, 84 maabarot, 21 work camps, 28 immigrant neighborhoods and abandoned villages, and 56 new immigrant neighborhoods on the outskirts of cities and in development towns. The number of Kupat Holim members stood at 366,000 households who together with their families encompassed approximately one million persons, most of them new immigrants who had arrived in the country between the years 1948–52. No other body among Israel’s health agents provided services of this magnitude; in fact, no other health agent wanted or requested to do so. Sirlin’s charges that Kupat Holim undermined the Ministry of Health services and its clinics had no factual foundation (see tables 5.1–5.3).

Despite Kanev’s attempts to defend Kupat Holim’s image and reputation during the maabarat period, the Ministry of Health’s criticism of the sick fund made it clear to Kupat Holim’s leadership that the ministry’s negative attitude towards the sick fund remained even after Sheba’s resignation. Under the new minister, the sick fund continued to feel threatened by aspirations to nationalize it—a goal that the new minister expressed openly. Now that the battle on the maabara front had subsided, or at least come officially to a close, Kupat Holim began to focus on expanding its operation on another front—in frontier areas close to the border, in immigrant neighborhoods, in new moshav settlements of new immigrations throughout the Negev and the Galilee, and the development towns that sprung up on the periphery.
Table 5.1. Members progression in Kupat Holim

<table>
<thead>
<tr>
<th>Year</th>
<th>Members</th>
<th>% of Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948</td>
<td>328,000</td>
<td>—</td>
</tr>
<tr>
<td>1949</td>
<td>475,000</td>
<td>44.8%</td>
</tr>
<tr>
<td>1950</td>
<td>690,000</td>
<td>45.3%</td>
</tr>
<tr>
<td>1951</td>
<td>875,000</td>
<td>26.8%</td>
</tr>
<tr>
<td>1952</td>
<td>900,000</td>
<td>2.0%</td>
</tr>
<tr>
<td>1953</td>
<td>960,000</td>
<td>1.4%</td>
</tr>
<tr>
<td>1954</td>
<td>975,000</td>
<td>1.9%</td>
</tr>
<tr>
<td>1955</td>
<td>1,000,000</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

Jewish community in 1955—1,500 million and members of HMO—1,000 million (64.5%)  
Source: Lavon Institute, Labor Archives, Kupat Holim files, IV-104-38

Table 5.2. Employee progression in Kupat Holim, 1948–55

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Employees</th>
<th>% of Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948</td>
<td>1898</td>
<td>—</td>
</tr>
<tr>
<td>1949</td>
<td>2475</td>
<td>30.4%</td>
</tr>
<tr>
<td>1950</td>
<td>3516</td>
<td>42.1%</td>
</tr>
<tr>
<td>1951</td>
<td>4600</td>
<td>30.9%</td>
</tr>
<tr>
<td>1952</td>
<td>5118</td>
<td>11.2%</td>
</tr>
<tr>
<td>1953</td>
<td>5733</td>
<td>15.8%</td>
</tr>
<tr>
<td>1954</td>
<td>6156</td>
<td>17.8%</td>
</tr>
<tr>
<td>1955</td>
<td>7066</td>
<td>14.8%</td>
</tr>
</tbody>
</table>

Source: Lavon Institute, Labor Archives, Kupat Holim Files, IV-104-38

According to Kanev, Kupat Holim did not encounter any opposition to, nor competition for, its work in the development of towns and rural agricultural settlements—not from the Ministry of Health, nor from Hadassah. The opening of a new clinic in a moshav or development town did not generate any expressions of disapproval from any quarter. Kupat Holim clinics completely controlled health care in the Galilee and the Negev. In 1953 a full two-thirds of the inhabitants of the State of Israel received their medical
Table 5.3. Budget of Kupat Holim

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget (IL)</th>
<th>% of Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1948</td>
<td>2,721,844</td>
<td>—</td>
</tr>
<tr>
<td>1949</td>
<td>4,534,614</td>
<td>66.6%</td>
</tr>
<tr>
<td>1950</td>
<td>7,626,962</td>
<td>68.2%</td>
</tr>
<tr>
<td>1951</td>
<td>11,797,961</td>
<td>54.7%</td>
</tr>
<tr>
<td>1952</td>
<td>20,760,083</td>
<td>76.0%</td>
</tr>
<tr>
<td>1953</td>
<td>39,293,770</td>
<td>42.1%</td>
</tr>
<tr>
<td>1954</td>
<td>46,431,180</td>
<td>25.2%</td>
</tr>
<tr>
<td>1955</td>
<td></td>
<td>18.2%</td>
</tr>
</tbody>
</table>

*Source: Lavon Institute, Labor archives, Kupat Holim files, IV-104–38*

care from Kupat Holim. If, in essence, this left countless inhabitants with no choice but to join Kupat Holim (and the Federation of Labor), a factor that would ultimately be to the sick fund’s detriment, competition or not—Kupat Holim’s decision to remain firm in its devotion to its founding philosophy of bringing health care to local communities was truly a boon under the harsh living conditions of the 1950s when transportation and carfare, like countless other things, were scarce commodities.

In December 1953 the State of Israel underwent a political upheaval when David Ben-Gurion resigned from the government. Unlike his previous resignations, Ben-Gurion did not relent this time, and Moshe Sharett was appointed to establish a new coalition government, and Pinchas Lavon was appointed minister of defense. In February 1954, Ben-Gurion returned to public service as minister of defense under Sharett. Yosef Serlin continued as minister of health throughout this period. Yet, Kupat Holim sensed that the threat to its independent existence had been sidelined—at least temporarily, by the change in Ben-Gurion’s status. While Dr. Sheba continued to be very active in formulation of health policy in the country, both in his position as administrator of the IDF’s central hospital—Tel Hashomer, his sway over the question of Kupat Holim’s independent status was diminished. The presiding director-general of the Ministry of Health, Dr. Btesh, did not possess enough political clout within the health system to take such a far-reaching and decisive move, and Kupat Holim did not consider him a serious threat although Btesh was in the habit of declaring publicly over and again that he had plans for nationalizing the sick fund.

Yet consolidation of health services in the hands of the ministry were afoot elsewhere. In 1953, the medical corps began to transfer the Tel Hashomer
Hospital over to Ministry of Health hands, following a decision on principle within the army not to operate its own independent hospitalization facilities, but rather to obtain such services for army personnel from government facilities, as needed. Thus, the IDF’s hospitals were gradually turned over to the Ministry of Health, transforming it into the largest provider of hospitalization services in the country. The political changes towards the close of 1953 and the structural changes in the ministry brought about some change in attitude of the state towards Kupat Holim—if not in practice, than at least in terms of official communicates. It appears that the growth tempered the ministry’s sense of inferiority to and intimidation by Kupat Holim. At the same time, the ministry became Kupat Holim’s primary competitor as a hospitalization service-provider. This competition had a far-reaching impact on the ministry’s hospitalization policy and funding of hospitalization by other public institutions, Kupat Holim in particular. For instance, it affected the setting the daily cost of hospitalization, investment in infrastructure and demands that the sick fund adjust its budget to Ministry of Health pricing, set according to the budgets of the ministry’s own institutions, and not according to actual expenditures within the sick fund and its institutions, in practice.

On February 28, 1954, Moshe Soroka summed up the issue in an address before a session of the National Supervisory Committee, entitled “Kupat Holim and the State.” Soroka discussed changes that had transpired in the six years since the Yishuv gained statehood—from the 1948 war to mass immigration, and summed up the work of Kupat Holim during this entire period. He opened his overview by quoting the words of the Ministry of Finance Levi Eshkol regarding the government budget during a speech in the Knesset a week prior:

We are happy that the public organized within the Federation of Labor’s Kupat Holim receives necessary medical service . . . The Israeli taxpayer wants the government to honor its responsibility to it and to many new immigrants in need of a doctor and a hospital.\textsuperscript{97}

In the wake of the new Minister of Finance Levi Eshkol’s statement, Soroka hoped that the federation lobby in the government, those who supported the continued existence of Kupat Holim as an independent entity, would press for and bring about a change in government policy, a change that would generate government financial assistance to the sick fund that would allow Kupat Holim to add and expand and improve its services.

Had times been normal, Kupat Holim might have had a chance, under the auspices of a new government, to change policies and general attitudes towards the sick fund. Changes in political realities, however, prevented a change in attitudes. In 1954 the Achdut Haavodah Movement withdrew from the Mapam Party, sending the political arena into a period of disequilibrium.
Table 5.4. Kupat Holim: Insured, institutions, personnel (1948–64)

<table>
<thead>
<tr>
<th>Category</th>
<th>1948</th>
<th>1964</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Population</td>
<td>328,000</td>
<td>1,790,000</td>
</tr>
<tr>
<td>Hospitals (number of beds)</td>
<td>643</td>
<td>2,981</td>
</tr>
<tr>
<td>Of them: In General Hospitals</td>
<td>388</td>
<td>2,417</td>
</tr>
<tr>
<td>In Special Hospitals</td>
<td>255</td>
<td>564</td>
</tr>
<tr>
<td>Convalescent homes (no. of beds)</td>
<td>567</td>
<td>2,121</td>
</tr>
<tr>
<td>Clinics</td>
<td>373</td>
<td>996</td>
</tr>
<tr>
<td>Physiotherapical and rehabilitation institutes</td>
<td>25</td>
<td>48</td>
</tr>
<tr>
<td>X-Ray institutes</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Laboratories</td>
<td>38</td>
<td>147</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>39</td>
<td>210</td>
</tr>
<tr>
<td>Dental Clinics (no. of chairs)</td>
<td>18</td>
<td>72</td>
</tr>
<tr>
<td>Mother-and-child stations</td>
<td>43</td>
<td>180</td>
</tr>
<tr>
<td>Personnel</td>
<td>2,600</td>
<td>12,487</td>
</tr>
<tr>
<td>Of them: Doctors</td>
<td>550</td>
<td>2,529</td>
</tr>
<tr>
<td>Nurses</td>
<td>640</td>
<td>3,631</td>
</tr>
</tbody>
</table>

Source: Lavon Institute, Labor Archives, Kupat Holim files, IV-104-38

As a result, the power of the General Zionists rose and fell intermittently, impacting on the delicate balance of powers within the coalition government and the political sector as a whole. The Sharett government tottered from one political crisis to another, clouding the general atmosphere, and fueling a sustained period of uncertainty and unrest. A host of simmering rivalries rose to the surface both within the Federation of Labor and between the federation and the ruling Mapai Party, against the backdrop of the Lavon Affair and bitter disagreement as to how the scandal should be handled, while widespread economic distress and growing security problems occupied the national agenda.\(^88\) The issue of the character of Israel’s health system was pushed onto the sidelines, for calmer times (see table 5.4).

Nevertheless, the issue became a minor issue for a brief moment towards the close of the year when Kupat Holim proposed that it establish a central hospital in the Negev in place of the small hospital operated by Hadassah in Beer Sheva. The concept opened a new front in the complex Kupat
Holim—Federation of Labor—government power matrix. While the issue of a hospital was objectively a local Negev issue, like every other issue that was subject to controversy between Kupat Holim and the government, here as well the issue was over principles.

The struggle to establish a central hospital in the Negev under its auspices, occupied Kupat Holim for most of the latter half of 1950. Involvement in the issue was intense, equal in magnitude to the energies invested in medical work in the maabarot in the first half of the decade. To a large extent, the health issue continued to be a constant companion to Israeli politics. The question of Kupat Holim’s role within the state occupied a key place within disagreements over the face of the country’s future health system, but was also part of a larger picture, one where health was only one of the playing fields where various interest groups and ideologies sought to gain a favorable position in shaping the character of the country while amassing personal and group clout.