

## **JEWS AND CORONAVIRUS**

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Jews are ‘long lifers.’ Everywhere in the world Jews live longer than the non-Jews around them. Jewish men in Israel have one of the highest life expectancies in the world. In 2017, they could expect to live to 81 years on average; women to 85 years. With respect to life expectancy, Israeli Jews, and especially men, surpass almost all high-income countries: the average life expectancy for men in OECD countries is 78 years and 83 years for women. None of this is new; whilst life expectancy has increased everywhere, the existence of a gap between Israeli Jews and other similar populations elsewhere has been present throughout the State of Israel’s existence. Nor is this unique to Jews in Israel. Jews in the Diaspora also live longer than the non-Jews surrounding them in all places where records are kept. The only exceptions to this rule were newly-formed immigrant Jewish communities from low income countries (e.g. the Russian Empire) moving to high income countries (the USA and the UK), but even there the longevity advantage of Jews resurfaced quickly as immigrant communities integrated into their new lives.

The Jewish longevity advantage is not due to biology in the strict sense of that word. What kills Jews less than others is what epidemiologists call ‘avoidable mortality’ – quite literally, mortality that can be avoided – i.e. if people behave in a way that is ‘health-aware’: exercising, not overeating or undereating, consulting doctors, avoiding substance abuse, not smoking, not drinking excessively, not engaging in antisocial behaviour and violence, indeed, not taking unnecessary risks in general. Jews are, on average, more health-aware than non-Jews, and that, historically, did not pass unnoticed. Philosophers and physicians in the past commented on the fact that, relative to non-Jews, Jewish behaviour is more reserved and less prone to risk. To give just one example, in a series of lectures delivered to students at the University of Königsberg in the late eighteenth century (later to become a book entitled *‘Anthropology from a Pragmatic Point of View’*), Immanuel Kant pointed out that “women, priests and Jews do not get drunk, as a rule, at least they carefully avoid all appearances of it, because their civic position is weak and they need to be reserved.” Note the explanation offered: it is the political vulnerability and powerlessness of Jews that stands behind the phenomenon of their greater sobriety. In short, Kant’s view was that Jews do not get drunk because they are afraid to enter an uninhibited state given their already-insecure social position. Their insecurity and fear – of appearing themselves, of being judged by others, of punishment – informs their behaviour, and, for Kant, likens them collectively to women who, to this day, have greater longevity than men.

What is the link between this and coronavirus? There are many ways to destroy one’s health and, it seems that Jews are less prone than average to be health-destructive with respect to many of them. For the specific purposes of considering coronavirus, the most important health-destructive behaviour to consider is smoking. Jewish populations, both in Israel and in the Diaspora, are less profoundly affected by smoking than others, which gives Jews a strong advantage in dealing with various diseases affecting lungs and the respiratory system. Smoking damages health by causing or worsening the course of a wide range of cancers, as well as cardiovascular and respiratory diseases. Of all organs, lungs and the organs of the upper aerodigestive system are most severely assaulted by smoking. According to the American Cancer Society’s second Cancer Prevention Study – one of the core

empirical sources behind later anti-smoking public health measures – the cardiovascular mortality of smokers is two to three times higher than the mortality of non-smokers, and the mortality from lung cancer and chronic obstructive pulmonary disease among smokers is 14-24 times higher than among non-smokers. In simple terms, smoking weakens the lungs. Coronavirus also assaults the lungs, so when coronavirus infects lungs that have been already weakened by something else, the result may be much worse than an equivalent assault on completely healthy lungs. Because Jewish populations have been less affected by smoking compared to others, we can be reasonably optimistic as to the effects of coronavirus on Jews.

I wish I could explain exactly why and how Jews are less affected by smoking. Perhaps it is all part of the bigger 'Jews are comparatively more moderate in their health destructive behaviours' story. Europeans and Americans took up smoking in very significant numbers in the first half of the twentieth century. The reality of damage caused by smoking remained contested for a long time. Smoking started as a fashion among high society before spreading to all social classes. Initially, it was almost exclusively a male habit, then it also spread to women. The adverse effects of smoking took decades to demonstrate, and anti-smoking policies took decades to implement. The epidemic of diseases related to smoking ravaged the world between the 1960s and the 1980s. And this is another important point to grasp about the way in which smoking kills: its full effects on the health of the population are delayed by about 20-30 years. Smokers typically start developing smoking-related illnesses not in their youth but when they age. So, the increase in smoking-related mortality in the late twentieth century occurred when the actual prevalence of smoking was already going down. Indeed, smoking is still the number one public health risk and the consequences of mass smoking will be felt at the level of population health for some years to come.

Importantly, however, no matter where one looks, the rates of mortality from smoking-related diseases have been considerably lower among Jews compared to non-Jews. A [study](#) published in 'Population Studies', a prominent demographic journal, indicated that in the 1970s-1990s, about 13% of all deaths among Israeli Jewish men aged 45 years and over were attributable to smoking; at the same time in English-speaking countries, the proportion of smoking-related deaths was about 30% of all male deaths, while in Southern Europe (Greece, Italy and Spain), it was about 20%. The [most recent data](#) indicate that Israelis are still at a considerable advantage when it comes to smoking-related mortality: today, death rates from cancer of the trachea, bronchus and lungs among men aged 65 years and over in the European Union are about 1.5 times higher than among men in Israel. The story of the Jewish Diaspora is much the same.

The coronavirus pandemic is occasionally compared to the 1918 Spanish flu pandemic. Just how far the comparison is appropriate in biological terms is beyond the scope of this essay, but there is something about the Spanish flu pandemic that is not at all well-known but worth knowing. It can help to make sense of the 'chances' of coronavirus among Jews today. The ferociousness of the Spanish flu is partly [explained](#) by the fact that in 1918 the flu virus did not act alone. It had help. It attacked people whose lungs were already weakened, not by smoking (it was too early for that), but rather by tuberculosis. Tuberculosis was genuinely endemic at that time in the West, with a large pool of people with the clinical disease and another large pool with the latent infection. In 1917 mortality from tuberculosis in the United States of America, for example, was higher than mortality from a stroke and only a little lower than mortality from heart disease, which is another way of saying that in the early twentieth century, tuberculosis was a central feature of life and a major cause of death. Thus, when Spanish flu attacked, it attacked populations with many weakened lungs. The death march of Spanish flu would not have been as spectacular as it turned out to be in the end without some interaction with tuberculosis. Incidentally, mortality from tuberculosis declined sharply after the Spanish flu pandemic because Spanish flu both took the lives of many people with tuberculosis whilst also reducing the size of the pool of infected individuals in the community.

Returning to coronavirus, the health profile of Jews, in Israel and elsewhere, makes them relatively resilient to it. That said, [others](#) have indicated, correctly, that additional factors should be taken into consideration in assessing the potential impact of coronavirus on Jews. Some Jewish communities in the Diaspora (not Israel) are rather aged, and age is a notorious risk factor with respect to coronavirus. Certain subgroups among Jews (e.g. the Orthodox) have intense religious lives which, epidemiologically speaking, translate into the frequenting of – and crowding into – places of worship and religious study. Strictly Orthodox Jews also have large families: the average household size in this sector is five, compared to three in Israel as a whole and about two in other Western countries. Contagious agents, such as coronavirus, love crowds. (It is also worth noting, in passing, that the *haredim* constitute a subgroup with especially high longevity, even among Jews.) The impact of these factors may offset the impact of the generally wholesome Jewish population health profile, to some extent. However, the importance of healthy lungs, at a population level, would be very difficult to neutralise. In short, positivity and optimism with respect to the outcome of the encounter of coronavirus with Jews are not unwarranted. Quite the contrary.