tion of Federal funds for the construction of the Washington Hospital Center as a replacement for three independent, nonprofit hospitals. This act required the District government to pay 50 percent of the net cost to the Federal Government because at that time a serious hospital bed shortage was evident in the District, and Congress felt compelled to meet that emergency.

Later extensions and amendments of that act took place, such as the 1951 amendment authorizing Federal grants of up to 50 percent of the cost of constructing or renovating hospital facilities generally within the District. The District of Columbia government was required to pay 50 percent of the Federal contribution. Such was reduced to 30 percent by a congressional amendment in 1958 to the Hospital Center Act for grants made after that time. Under the 1951 and subsequent amendments, grants totaling $17,420,453 were made for hospital projects having an estimated total cost of $44,400,000, with the fact being today that practically every public and private hospital in the District of Columbia having participated in such program. That act expired in 1962.

In 1962 Congress enacted legislation (Public Law 87–460) authorizing special Federal grants not to exceed $2.5 million for 50 percent of the cost of constructing an addition to George Washington University Hospital. Funds for this purpose were appropriated by Congress in fiscal year 1964, and the project is now completed.

In addition to the Hospital Center Act and Public Law 87–460, both of which applied solely to the District, Federal financial assistance has been given for the construction of hospitals and other medical facilities generally in Washington through two generally applicable Federal programs—the wartime defense housing and public works program, commonly known as the Lanham Act, and the hospital and medical facilities construction program, usually called the Hill-Burton program. Under the Lanham Act, two hospitals in the District received a Federal contribution of $5,655,000. Under the Hill-Burton program, a total of $7,194,000 in grants was approved through fiscal year 1966 for 27 projects in the District of Columbia.

LOCAL PRIVATE FUNDING UNAVAILABLE

The medical necessity for the 1946 Washington Hospital Center Act and its amendments thereto arose because of the inability of sponsors within the District of Columbia to raise private capital for hospital construction to meet the statutory matching requirements of the nationwide Hill-Burton program. As a result, the District was unable to use certain funds allotted to it under that program.

Consequently, in 1961 President Kennedy directed the Department of Health, Education, and Welfare to examine into the District's continuing need for special assistance to meet health needs because of the District's unique geographic location. Factually, Washington, D.C., is the central city of a metropolitan area wherein some 40 percent or more of the patients who are required to utilize hospital facilities within the District of Columbia are residents of nearby Maryland and Virginia. This bill is the outgrowth of the findings of the Department of Health, Education, and Welfare originally submitted to the Congress in 1965.

This bill is designed to meet special needs for hospitals and other medical facilities in the District of Columbia by reason of its being the Nation's Capital and the central city of a large metropolitan area, with an estimated 2½ million population expected to increase to 3 billion by 1970.

The special Federal aid made available by the Congress over the past 20 years for construction of District medical facilities indicates that the Hill-Burton, mental retardation and mental health center construction programs provide only a partial answer to the problem of financing the construction of such facilities in the District.

First, sponsors of projects for such construction in the District of Columbia experience serious difficulty in raising the non-Federal share of the cost thereof. Second, the allotment of Hill-Burton funds to the District, which in general is based on per capita income and population, is low in relationship to the facility construction demands, considering that hospitals within the District itself care for a substantial number of residents from suburban Maryland and Virginia.

Nonprofit medical facility groups seeking contributions in Washington do not have available to them much of the important support from corporate gifts which are available in other communities. Corporate gifts generally make up to 60 to 70 percent of the total private funds subscribed for constructing hospitals