in the District of Columbia experience serious difficulty in raising the non-Federal share of the cost thereof. Second, the allotment of funds to the District, which takes into account per capita income and population, is now in relationship to the facility construction problem.

Nonprofit medical facility groups seeking contributions in Washington do not have available to them much of the important support from corporate gifts which is available in other communities. Corporate gifts often make up 60 to 70 percent of the total private funds subscribed for constructing hospitals in cities the size of the District; and more than half of these corporate gifts come from manufacturing corporations. The District, however, has only about 14 percent of the per capita potential of metropolitan areas of comparable population for receiving contributions from such manufacturing corporations.

Another reason for the difficulty experienced by project sponsors in the District in securing funds to meet the non-Federal share of the cost of construction of hospitals and other medical facilities is that, although the average income here is among the highest in the country, a large proportion of those on the upper part of the income scale are temporary residents who do not feel an obligation to support capital improvement drives to the same extent that permanent residents here or elsewhere do, or indeed, to the extent that these same temporary Washington residents feel in relation to their own "home" communities. This factor has made it very difficult to raise money for these facilities in the amounts which might be expected if the average income alone were used as a guide.

A unique medical facility utilization and construction problem exists in the District because of the large number of patients from other "States" who occupy general hospital beds in the District. A survey conducted in 1958 showed that approximately 40 percent of the patients in District hospitals at that time came from outside the District, primarily from the Maryland and Virginia counties in the metropolitan area. A study of the residence of patients admitted to general hospitals in the District during the week of February 25–March 3, 1962, showed similar results; only 58 percent of those patients were District residents.

If District of Columbia General and Freedmen's Hospitals were excluded from this latter study, a significantly higher percentage of patients from outside the District would be found, ranging up to nearly 60 percent in the case of Georgetown University Hospital.

The need for Federal aid is most acute in the case of long-term care facilities. The lack of private fundraising potential for construction of these facilities is even more pronounced than in the case of short-term care facilities—as demonstrated by the fact that the District has been unable to use much of the money available to it under the Hill-Burton program for construction of long-term care facilities, due to inability to raise the required matching funds.

For the reasons cited above, special Federal assistance for the modernization of hospitals and the construction or modernization of other medical facilities in the District of Columbia is clearly required. To make up for the loss of normal private sources of support caused by the presence of the Federal Government in the District, we believe it is necessary to have the Federal grants cover up to two-thirds of the cost of construction projects for a long-term care facility, a diagnostic