

Sergio Brenna  
**From Local Social Health Units to Community Houses of the  
PNRR: again between Ford and Garnier**

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Abstract

The dichotomy between the proposals for a healthcare organization conceived as part of the social equipment of the settled community or as an elective terrain of a model of corporate introversion, which had its most evident manifestation in Tony Garnier's proposals for healthcare equipment for the Citéindustrielle and in the example of the Ford Hospital in Detroit, it is paradigmatic of the differences between the different concepts that have shaped the origins of the modern hospital and are proposed today as fully relevant in conceiving the articulation of healthcare equipment through a typological organization aimed to adequately provide from time to time a unifying register of the functioning of both the basic healthcare bodies and the associated and collective life functions of the settled population.

Keywords

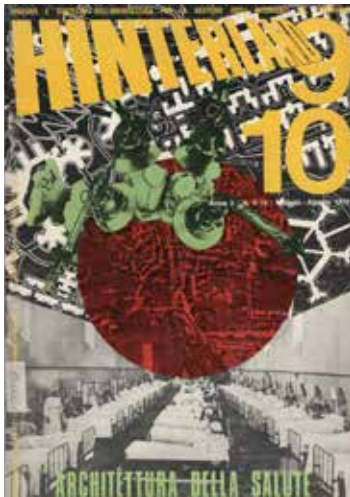
Health architecture — Hinterland — Community houses — Cité industrielle — Ford Hospital

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In conjunction with the elaboration and approval of Law No. 833 on December 23, 1978 (Establishment of the Italian National Health Service), commonly known as the Health Reform, I was engaged as a young research fellow in the research group led by Prof. Guido Cannella at the Faculty of Architecture of the Polytechnic University of Milan. The research focused on investigating the potential impact of the organization based on the Local Socio-Health Units (USSL) on the development of hospital and healthcare building typologies. The establishment of USSL was envisaged by the national framework law, aiming for a unified approach to the prevention of health conditions. This approach aimed to bridge the diagnostic gap between the traditional family doctor and the general or specialized hospital, focusing primarily on therapeutic functions for established diseases.

As is known, the initial goal of articulating different organizational levels based on the health, social, and settlement conditions of various contexts gradually eroded. This erosion began with the transformation of Local Socio-Health Units into Local Health Companies, continuing with the conditions imposed by the “historical expenditure” principle, which transferred the management of the health organization to the regions. The situation risks worsening with the proposal of “Differentiated Autonomy,” which finances regional healthcare based on their own fiscal resources rather than the service delivery needs. The gap between the so-called “general practitioner,” a private professional operating “under agreement” in their private practice, and the bureaucratic control over the free or semi-free provision of drugs and access to diagnostic or therapeutic facilities has persisted.

However, I do not intend to anticipate a conclusion here. Instead, I



am interested in reaching an internal analysis of typological and settlement forms. This is distinct from a political-social and organizational-administrative debate currently underway, especially with the proposal to finance the construction of so-called “Community Houses” through the resources of the PNRR (Italian National Recovery and Resilience Plan). These houses aim to be a continuous reference point for the population, incorporating infrastructures such as computer facilities, sampling points, and polispecialistic instruments. The goal is to ensure the promotion, prevention of health issues, and patient care by the reference community.

That remote research activity, modestly funded by the Ministry of Public Education as part of regular funds and independently of the specific occasion provided by the coincidence between the investigation’s subject and the development of institutional reform, published its results in an issue of the magazine *HINTERLAND - Design and context of architecture for territorial interventions*, vol. 2, No. 9-10, May-August 1979, programmatically titled “Health Architecture.”

Guido Canella, both the director of the research and the magazine, in the editorial titled “The hospital between internal history and external history,” noted how

No other building type has remained subject, even in the modern era, to intrinsic pre-conceptions of functionalist necessity as much as the hospital (...) There is no doubt that studies on architecture and the city, at least for fifteen years now, have registered an impulse decisive precisely from having admitted the necessity and practiced the structural encroachment towards a more comprehensive external history, to be understood as reason, natural even before moral, in reducing the technical, sociological, economic, etc. settings.

It should also be noted, however, in the majority of cases, the lack of return, not formally analogical but effectively operational, from the historical excursion to planning; so that this remains abandoned to itself, cut off from any potentially innovative cognitive enrichment. (Canella 1978).

In that magazine issue, I published two contributions resulting from research on the historical evolution of the relationship between medical-health knowledge, the social organization of their delivery forms,

**Figg. 1-3**

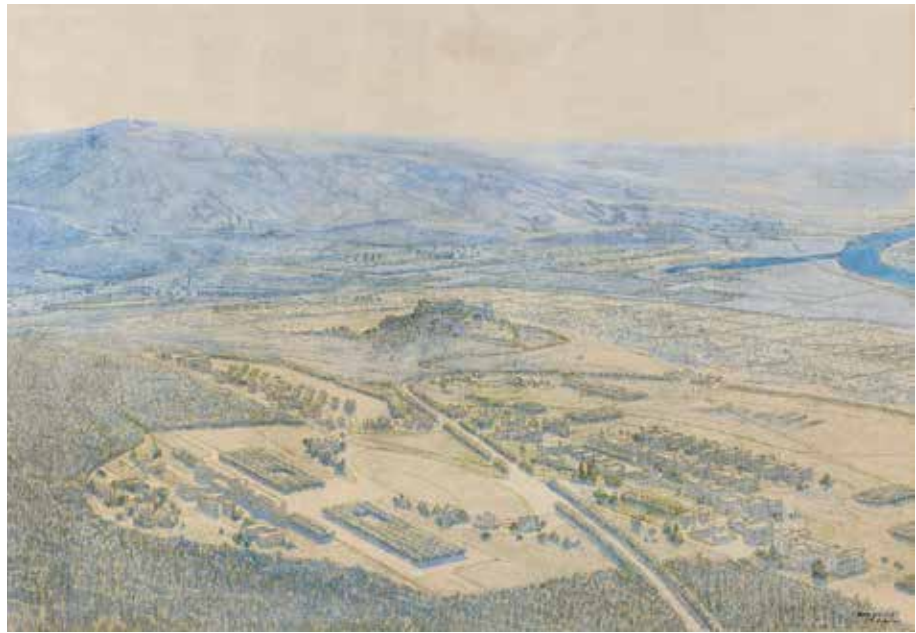
Cover and internal pages of the magazine *Hinterland*, 9-10, may-august 1979, titled *Architettura della salute*.

**Fig. 4**  
Henry Ford Hospital, Detroit,  
1915.



and the settlement typologies of the buildings corresponding to them. One summary outlined the evolution from Roman *Valetudinaria* to the 17th-18th century *Hotel des Invalides* in Paris. It traced the identification of war as the exclusive “social cause” of disability and illness to address. This was in contrast to the compassionate assistance provided by religious organizations, which remained closely intertwined with the goal of segregating those with possible epidemic spread. The article also covered the emergence and spread of the “pavilion” hospital typology in the 17th-18th centuries. This coincided (and somewhat anticipated) with the birth and spread of the “etiologically unitary” concept of disease and cure (“one cause for every disease, one cure for every cause, one location for each cure”). The pavilion typology deteriorated into the almost infinitely dispersive arrangement of specialized pavilions in some German hospitals of the Bismarckian era. The 20th century saw the emergence and prevalence of the “monobloc” hospital, where the continuation of specialization in separate departments found distributive efficiency in mechanized vertical connections. These connections extended from underground services to ground-floor reception, specialized therapy and wards on various floors. This was, however, with the unusual exception of Le Corbusier’s project for the new Hospital of Venice, where wards were placed separately on the top floor in a scheme inspired by the urban organization around “*campielli*,” derived from the urban context.

Although I briefly mentioned this chronological-typological overview<sup>1</sup>, another full-page article focused on two nearly contemporary examples representing a strongly dichotomous moment in the opposing concepts of the relationship between the hospital organism and the urban context. This contrast influenced the configuration and role of the contemporary hospital: the Ford Hospital in Detroit (around 1911-1914) and Tony Garnier’s studies for his idea of the *Cité Industrielle* (1901-1904), followed by the subsequent opportunity to implement its typologies in the Lyon hospital organism (around 1915). More than the transition from the pavilion typology to the monobloc, which seeks justification in exclusively health and distribution-related reasons, what needs to be grasped is the prevalence of a concept that isolates the hospital organism, emphasizing its corporate technical-organizational characteristics over those of a health organization. The latter is articulated to reconnect various organisms and typologies with

**Fig. 5-6**

Tony Garnier, Cité Industrielle (1901-1904). Plan and view of the hospital area

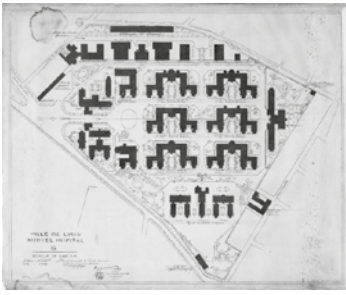
the socio-settlement features of the user population.

Ford, in fact, acquired the hospital building when it was already under construction by various philanthropic city organizations. Rather than participating in philanthropic contributions, Ford preferred to take direct ownership and management. This way, he could imprint his concept of corporate organization based on a series of fragmented functions, somewhat analogous to the work in his factories. Upon arrival at the hospital, the patient underwent a series of predetermined diagnostic assessments independent of the specific reason for admission. These assessments proceeded separately to converge only at the end to reconstruct the patient's clinical picture and initiate specialized therapy.

This choice was primarily motivated by the goal of minimizing, in the determination of the correct diagnosis and management of therapy-stay, the influence that individual healthcare operators (doctors or nursing staff) could have on the organizational structure predetermined by the factory engineers' design. This influence pertained to optimizing the staff/user ratio and reducing routes and spaces.

Although Tony Garnier's hospital typology, initially apparent in his Cité Industrielle project of 1901-1904 and later in the concrete realization of the Lyon hospital in 1915, might seem entirely part of the pavilion hospital at first glance, a closer examination reveals that his organizational concept of the hospital typology arises more from being – like other socially oriented facilities and residential district typologies – a functionally demonstrative organism of a unitary typological system. This system, albeit diverse, aims at the overall objective of conceiving a modern “healthy industrial city.”

In a way, this vision anticipates initiatives in the United Kingdom, which, from 1935, experimented with Pioneer Health Centers. Although this was applied voluntarily to a limited number of families in the same community, it extended health management to the general living and working conditions of the user population. This initiative led to a network of health centers promoting a new generalized role of health prevention within the community's associated life activities. These activities included health functions alongside facilities such as swimming pools, public baths, nurseries, gyms, restaurants, and community meeting rooms.

**Fig. 7-8**

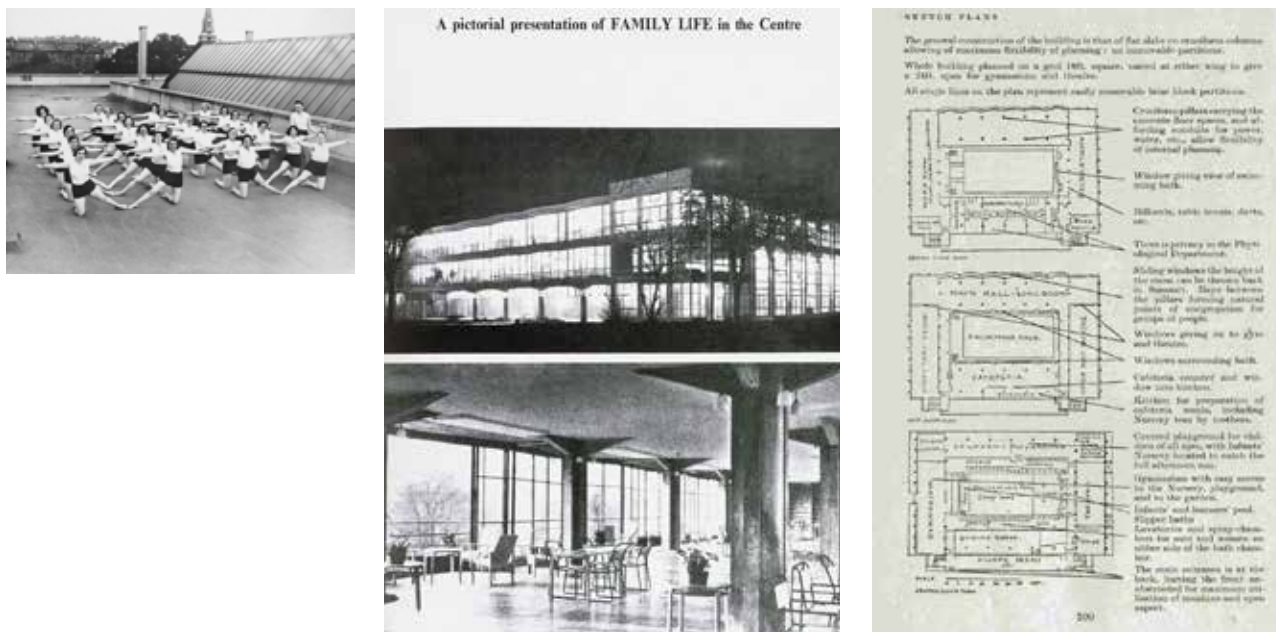
Tony Garnier, Hôpital E. Herriot, Lyon, 1913-33. Plan and view of the hospital area.

Although interrupted during the war, the experiment was reintroduced in 1947 in connection with the implementation of widespread health reform. Regarding healthcare structures, it proposed the creation of a vast network of health centers, especially connected to areas reserved for social services in new towns. The aim was to overcome both the Victorian pavilion equipment erected in the 1920s and the more recent large hospital complexes suffering from gigantism that weighed down efficiency and functionality due to the congestion of both functions and the resulting patient load. The goal was to create a new articulation capable of responding to the ongoing territorial decentralization needs and the increasing importance of preventive medicine. However, the limited number of implementations resulting from the provision of areas reserved for health services as part of social service facilities did not reveal a more precise typological characterization. This was in contrast to the prevalence of narrow hygienic-functional distribution diagrams.

The dichotomy between the proposals of a healthcare organism conceived as part of the social facilities of the settled community or as the elective ground of a model of corporate introversion, as evident in Tony Garnier's proposals for industrial city facilities and the example of the Ford Hospital in Detroit, seems to me still paradigmatic today. It illustrates the differences between the various conceptions that shaped the origin of the modern hospital. These conceptions are re-emerging today as relevant in conceptualizing the articulation of health facilities through a typological organization aimed at providing an appropriate unifying register of functioning for both basic health organizations and the associated and collective life functions of the settled population.

Over the years, hospital organization has continued to be a preferred application ground for advocates of a managerial technicism that evades the real problems posed by the need to redefine the organization and typology of health organizations on new bases of compliance between socio-settlement conditions and health facilities. This is done to achieve a higher degree of coherence and innovation in health facilities in relation to public general service spaces.

The opportunity offered today by PNRR funding for the construction of so-called "Community Houses" should be seen again as the possibi-



**Fig. 9-11**  
Sir Owen Williams, Pioneer Health Center, Peckham, 1935.

lity of returning to pursue the goal of articulating health facilities into differentiated organisms. These organisms are based on health, social, and settlement conditions of various contexts, starting from the need to rethink the vision within the integrated endowment spaces of public services for settled communities.

From a typological perspective, this requires the ability to develop solutions in which Community Houses can disaggregate the current autarchic compactness that has developed within hospital corporatism. Instead, they should promote the reintegration of basic health activities around the social and collective moments, both internal and external to the health function. Moreover, it requires a reaffirmation of the goal of public and collective design in the configuration of facilities and public spaces. This is in contrast to the prevailing concept of “urban regeneration,” which is almost entirely delegated to proposals from private real estate developers in a sort of “competition tender” of ideas and solutions inevitably subject to their inherent playful-consumeristic vision.

## Notes

<sup>1</sup> Hinterland magazine had a page structure that allowed, in addition to publishing the main text in two columns on the left-hand page, the development of a catalog of images with text in five smaller columns (which occupied the remaining part of the left-hand page and the entire right page) thus allowing a parallel story divided between texts and images. See the figure on page. 53 (ndc).

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Sergio Brenna, former full professor of urban planning at Politecnico di Milano has been the author of projects alternatives to those in progress on main areas of large urban and territorial transformations of Milan and Lombardy context. Among his books: *I ritorno al futuro della cité industrielle: dopo Ford, torniamo a Garnier* (2000), *De Finetti 1946-1952. L’urbanistica dilatata di un pubblico amministratore schumpeteriano* (Euresis, 2003); *La Città: architettura e politica* (Hoepli, 2004); *Milano, dall’esterno e da lungi* (Gangemi, 2006); *La strana disfatta dell’urbanistica pubblica*. (Maggioli, 2009); *La strada lombarda. Progetti per una Milano città madre della propria cultura insediativa* (Gangemi, Roma 2010).