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Architecture and cities of health: Places and Community Health Centers

Carlo Quintelli

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Caring Architecture in the Middle Ages: Models and Antimodels for the
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- a) short essays between 12,000 and 14,000 characters (including spaces), which will be submitted directly to the double blind peer review procedure;
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For the purposes of the assessment, the essays must be sent in Italian or English and the translation in the second language must be sent at the end of the assessment procedure.

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ARTICLES SUMMARY TABLE

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4	1047	mag-23	Long	Peer (B)		Yes
5	1050	giu-23	Long	Peer (A)		Yes
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NEXT ISSUE

N. 66-67 october 2023-march 2024

**The evocative force of architecture.
Projects for a memorial monument**
edited by Gentucca Canella

The double issue 66-67, outcome of the call, aims to open a reflection on the topic of the *Memorial Monument* by actively engaging PhD students from Architecture Schools in a design competition, with the mandatory inclusion of a sculptor in each group.

We wonder, in fact, if it shouldn't be considered useful, or even necessary (especially in an emergency situation like the current one), to again dwell on a theme: the Monument, which is little practised in its contextualised memory. This theme is to be understood, therefore, first in its relationship between sign and ideological intention, among elements of composition and plastic tension of the arts and construction techniques, until imagining a new role of collective condenser that is wholly practicable in its entire breadth.

The project assigned to the PhD students and sculptors for a "commemorative" memorial in five contexts of unique ideal, political, and symbolic – the relationship between the reconstruction of the social system and education for national independence and the architecture of the "Three Worlds" (the Art Schools in Havana, 1961-63, and the "Zero School" in Eritrea, 1970); the "monumental" out-of-scale for the poorest classes of Algeria (the large square of the "two hundred columns" in Climat de France, 1955-57); the construction of a "social order and a fruitful path of artistic lexicon" for a new "city of children" (the Istituto minorile Marchiondi-Spagliardi in Baggio, 1953-57); the identification and recognizability of a necessary and due "territoriality" and citizenship of migrants and burials (the massacre in Lampedusa on October

3, 2013) –, significance deliberately reintroduces certain structural constants of moral commitment, critical content, but also an inseparable connection between architectural representation and sculptural element, already present in some emblematic, mostly unrealized, cases of young protagonists of the late Italian twentieth century.

A “gestational struggle” that seems to find anticipation even in the design competitions of those years. In «L'Espresso» of 30 December 1962, in an article entitled *Il monumento di Cuneo. Dieci interpretazioni della Resistenza* (“*The Cuneo Monument: Ten Interpretations of the Resistance*”), Bruno Zevi, with profound engagement, commented thus on the conclusion of the first round of the Competition:

“In delivering the judgement of the first-round competition to the mayor, the members of the committee were visibly moved. The whole force of Italian art had responded to the call for the monument to the Resistance: 62 projects drawn up by hundreds of architects and sculptors comprised an unprecedented participation in a competition: from the most established figures to the youngest, everyone had enthusiastically given their best...In Cuneo, the monument isn't just evocative, it signals the link with the new Resistance in the context of a political recovery”.

On the other hand, if it is true that the task of an architecture magazine is also that of promoting new directions, new lines of inquiry, we believe that involvement in a graduate-level design competition may enable experimentation with a trend reversal trying to strengthen, at least in this case, the design phase with research.

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Carlo Quintelli
Architecture and cities of community health

Abstract

Compared to a new health demand, particularly after Covid 19, what is the contribution of architectural design to the responses? First of all, that concerning the structures responsible for the health services spread across the territory, an expression of basic medicine, which the population can easily access by virtue of the proximity of the settlement and a consequent familiarity of relationship with the medical and nursing staff. New decentralized primary care and treatment units that move from the name of *Health Houses* to that of *Community Houses* through Mission 6 Health of the PNRR (National Recovery and Resilience Plan). A variation that is not only nominalistic, in relation to which architectural project research can only interpret a social culture of care, according to an open and experimental disciplinary direction but capable of providing the main operational reference presuppositions in terms of urban role and typo-morphological quality of the designated spaces.

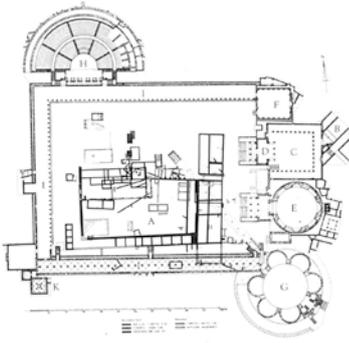
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Health Center — Community center — Health architecture — Health cities

While quoting Musil's axiom (1957) dedicated to «the famous architect», for which «modern man comes into the world in a clinic and dies in a clinic: consequently he must also live in a clinic!», in a issue of the magazine *Hinterland* entitled *Architecture of health*, Guido Canella went so far as to note, among other things, that «the architects of the Modern Movement have mostly retreated in the face of the hospital device, leaving it to the particularisms of health engineering» (Canella 1979).¹

Looking instead at the last decades, a series of architecturally significant interventions of the hospital type seems to emerge, perhaps more in the international field and with less restitution in Italy, something common to a good part of the public architecture of our country² (*Il Giornale dell'Architettura*). These are new interventions aimed at renovating and increasing a hospital building heritage which in many cases is inadequate with respect to the most advanced care practices and patient expectations, where functional construction and logistics engineering is often combined with more responsible for defining the comfort of the environments rather than characterizing the formal structure of the spaces of the healthcare organisation. This role is certainly not always reductive but has often been limited to the sole mitigation of mechanical-sanitary rigidity through recommendations, according to an obvious expectation, regarding the plans for the liveability and welcoming of the environments, the sustainability and recyclability of the materials, the quality of the equipment and furnishings for psycho-physical wellbeing, all packaged through the aestheticisation of the building envelope according to captivating graphic and chromatic configurations with a *green* denotation.³

Now, while the contribution of the architects was aimed at attempting to humanize increasingly technologically sophisticated hospital machines,



the no man's land of the facilities in the area - often made up of offices of individual general practitioners or at most of affiliated polyclinics located in condominiums or tertiary buildings fragmented - in March 2020 it was overwhelmed by the first pandemic wave, highlighting the lack of places and structures of a healthcare system that should have constituted the first line of defense against generalized contagion, between lack of local care and clogging of hospitals contributing to the high mortality rate.

Added to this painful experience of historical importance is the looming on the horizon of a further risk, at this point no longer attributable to the emergency data, concerning the lack of a strategy for structuring a healthcare system capable of decentralizing itself and becoming widespread throughout the territory. That of the aging population and a consequent series of cases where the onset of multi-pathological subjects can assume exponential dynamics, in a context aggravated by the change in family structures and social fragilities of a predominantly economic nature but not only.²

If we then want to understand the general delay in terms of awareness, interpretation and research in the architectural case for the structures once defined as *Health Houses*, we must consider that the issue, in a strictly healthcare sense, arises only within the National Health Plan 2006-2008 (Presidential Decree 2006). That detailed document of guidance for health policies also included the intent to reform the primary care system, where

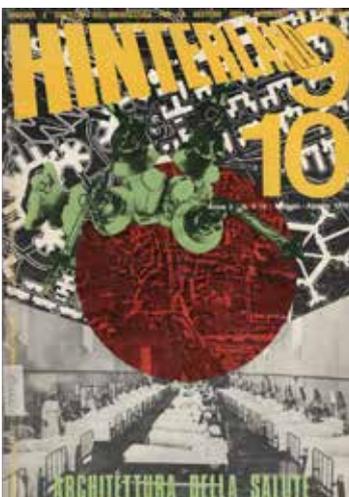


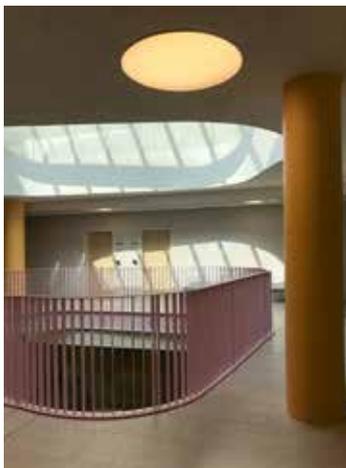
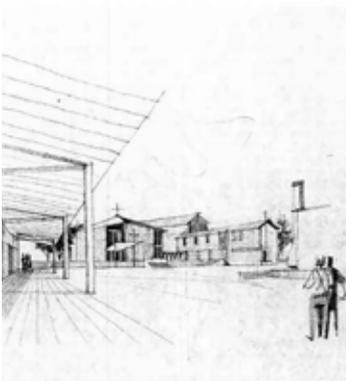
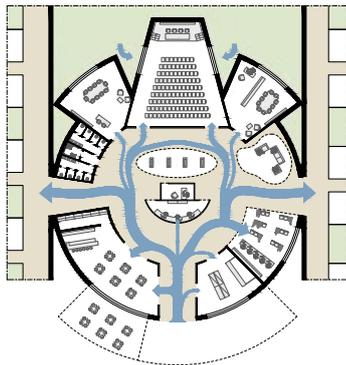
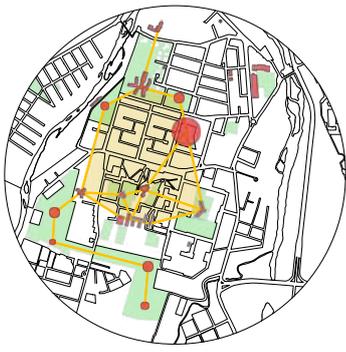
«increasingly aggregated and integrated forms of organization were hoped for, also aimed at continuity of care doctors and outpatient specialists, who allow, in single locations, the response to the health needs of citizens for 24 hours, 7 days a week [...] in suitable structures, with minimal building and technological characteristics».⁴

A planning direction which, while calling for 'suitable' and therefore typologically dedicated structures, significantly refers to 'building characteristics', and not architectural ones, with reference only to the laconic criteria for identifying the minimum requirements for healthcare facilities dictated by pre-existing legislation (Presidential Decree 1997).⁵

For a more specific definition of this new structure of the basic health service, starting with nominal identification, we will have to wait for the 2007 ministerial conference entitled *La Casa della Salute (The House of Health)*⁶. On that occasion, the then Minister Livia Turco spoke in explicit terms of «a place of recomposition of primary care and continuity of care», of a set of integrated activities through a «spatial contiguity of services and operators [...], an active and dynamic center of the local community» (Turco 2007). For the first time, the concept of space is making its way as a fundamental tool for relational emancipation between healthcare workers, even if the role of architecture, as a discipline responsible for researching its morphological quality and urban meaning, starting from the positional one, still remains essentially hidden.

Following the modification of Title V of the Constitutional Law with significant repercussions on health matters, the operational interpretation of the Casa della Salute will become the prerogative of the Regions. In the most active and sensitive contexts to health issues, an experimental design and operational path will thus be determined, monitored and implemented through subsequent improvements, with which innovation in health care and prevention activities takes on further consistency but above all where the extension is envisaged and integration of services in a socio-health and social perspective. A maturation of the healthcare model in a community sense which corresponds to, and in certain aspects will tend to exceed, the reference guidelines of the WHO and the European Health Program 2014-2020.⁷ A process of significant advancement which, however, once again,





only partially questions the design contribution in terms of the quality of the architectural spaces and the relationship with the urban structure.

Subsequently, following the Health mission envisaged in the PNRR⁸ (2021) and the consequent Ministerial Decree aimed at defining qualitative, structural, technological and quantitative standards relating to territorial assistance, in the context of an urgent implementation which required respecting the timescales dictated by the European funding, the further push will be created towards a concept that will evolve from a House of Health into a *House of Community*⁹ (Ministry of Health 2022). A significant step forward towards a model, previously only explored and now better described, on healthcare initiative, on prevention strategies, on programming derived from cognitive methodologies of population stratification, according to an integrated perspective, of evident community value, for the holistic care of the person also in terms of their social-healthcare and social-welfare needs as well as their purely healthcare needs.

Now, in the face of this new era of political-health direction and planning of State investments dictated by the PNRR¹⁰, the role of architectural design in the creation of quality structures no longer appears to be postponable, or reducible to a contribution of secondary importance, i.e. capable of best interpreting the functional, fruitive and representative needs of *Community Houses*.

The recent pandemic past has aroused the interest of Italian architectural culture, producing a rich framework of reflections and proposals¹¹ (FAM-Magazine 2020), regarding for example the themes of accommodation capable of dealing with the emergency conditions of *lockdown*, proximity to essential urban services in every neighborhood context, of the decentralization of settlements towards areas with low urbanization thanks to teleworking technologies. A reflection in the disciplinary field which also emerged at the level of public debate when the unrealistic proposal of pavilion-type vaccination centers emerged, fortunately not built, which should have arisen in every central square of Italian towns and cities.¹²

A reference framework of experiences and dynamics, even contradictory ones, where however the hope, with regard to *Community Houses*, should prefigure an architectural design capable of going well beyond the operations of building adaptation, partial reconversion or just makeover of facade with renewed signs, as happens in some contexts conditioned by an insufficient political and administrative culture even before a technical one. According to current events, the recent cut in PNRR funds, concerning various expenditure items for works that cannot be carried out by the 2026 deadline, also includes those intended for many of the new structures for *Community Houses*¹³. A planning accident, partly due to the inefficiency of the technical-administrative apparatus but also to other structural factors, in particular the increase in construction costs given by the inflationary push and the energy crisis resulting from the Russian-Ukrainian conflict. An implementation completion de facto postponed to future funding but which, at the same time, could allow for more adequate research and definition of the contents and methodological criteria for an architectural design currently substantially devoid of experience and previous disciplinary references.

This issue of FAM, aware of a transformation of the public health service with clear impacts on the built city and even more so on the lived one, would therefore like to mark a further cognitive step, in many ways unprecedented, capable if nothing else of directing attention towards an architectural project specifically dedicated to the new typology of the *Community House*. An investigative report which, at least in part, makes use of the advancement of a PNRR research conducted on the topic by a group from



the University of Parma, through the perspective of architectural design in a typo-morphological and urban key.⁷

The series of contributions opens with Enrico Prandi who, with an analogical perspective on the topic in question given the prevalence of the hospital type, retraces the historical forms of health architecture in dialectics with urban phenomena, according to an evolutionary dynamic in which the design of spaces contributes significantly to the characterization of the different healthcare practices detectable in social history.

This is followed by a reflection of mine, in terms of the epistemology of the project, aimed at bringing out some reasons for a typo-morphological research which would be capable of prefiguring and giving orientation to the definition of places and architectures congenial to this new culture of care, strongly characterized by community dimension intrinsic to the scale of urban living.

Giuseppe Verterame reads in particular the relationship between *Community House* and the settlement structure of the city through the perspective of the urban potential of this new typology in terms of positional, aggregative strategy, of complementarity with other services and public spaces, whose contribution is particularly significant to the within urban regeneration processes.

The point of view of the planning and organizational project of the social and health services of the *Community House* is brought to the reader's attention through an interview with some managers of the Territorial Assistance Sector of the General Directorate for Personal Care, Health and Welfare of the Emilia Romagna Region, as a significant testimony to the degree of complexity but also of sophisticated innovation that lies behind the establishment of these structures managed at the level of local, regional and municipal administrations, and of the responsible public health bodies. Antonio Nouvenne returns problems and aspects emerging from the field operations of local authorities committed to interpreting the role of the *Community House*, within a transition that is not only organizational but also of a cultural and professional nature on health and welfare practices⁸. To broaden and at the same time focus our gaze on the topic, following are the national and international case study selections regarding recent architectural structures dedicated to primary, extra-hospital social and healthcare services, described respectively by Alessia Simbari and Sahar Taheri. A first exploration which, while taking into account, in the international field, the formal and functional variables conditioned by the different welfare and social fruition systems of the host countries, is able to bring out the important role of the architectural culture that denotes primary health centers within different urban contexts.

Furthermore, to better grasp the rich framework of available experiences, some exemplary cases are presented, selected for typological originality, linguistic characterization, urban role, described and argued by the relevant architects and designers in European contexts such as Spain and Greece rather than in continents and more distant cultures such as Africa and Australia.

On the level of a more general historical recognition, Giorgio Milanesi analyzes the first symptoms of a civilization of assistance not separated from that of medical care starting from the early Middle Ages up to the proto-hospital evolution on the threshold of the modern age. These observations which, analogically, can also prove to be of great interest for our contemporaneity with respect to a widespread healthcare system which historically precedes the epicentric logic of the modern hospital.

The dialectic between architecture and healthcare culture is also explored in depth by Sergio Brenna in the most recent historical phase of the twen-

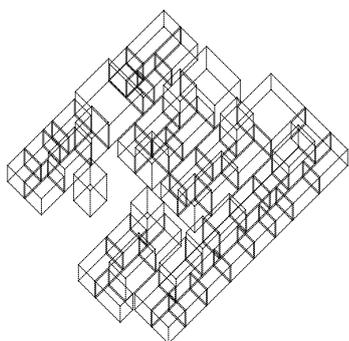
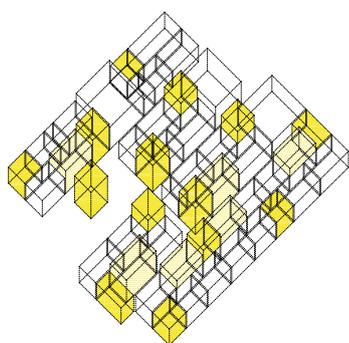




tieth century, where the modeling of the hospital structure seems to be compared between the efficient and self-referential hypothesis of Henry Ford and that physiologically related to the demands of the urban society of the *Cité Industrielle* according to Tony Garnier. The latter is a reference which in some respects introduces the problem of the community factor in relation to healthcare which is the subject of our attention.

In conclusion, the hope is that this collection of short essays of an introductory, critical and exemplary nature can be useful for the research of the experimental project, for the designing architect as well as for the commissioning and managing body, as well as for the operators and users of these new services to which we cannot help but attribute a particular civil value, even beyond the mere satisfaction of the demand for health that society continues to address to us.

A path of reflection on the design directions that are still at the beginning but which already prefigures a going “beyond” the current architectural experience on *Community Houses*.



Notes

¹ The role of architecture as a discipline responsible for the logic of “humanization” of hospital structures can be seen from the criteria of the “decalogue” of the ministerial commission of 2001, chaired by the then minister Umberto Veronesi and coordinated by the architect Renzo Piano, later brought back to document hospital engineering *Principi guida tecnici, organizzativi e gestionali per la realizzazione e gestione di ospedali ad alta tecnologia e assistenza*, scientific responsible Maurizio Mauri, Monitor n.6, Roma 2003.

² In Italy the percentage of over 65s is increasingly approaching one third of the population with a life expectancy of 81 years for men and 85 for women, a trend therefore favorable to the increase in the criticality of the state of health in a general aging scenario. See about it *Relazione sullo Stato Sanitario del Paese 2017-2021*, edited by Ministero della Salute.

³ Emilia-Romagna is among the Regions most capable of developing a systemic and integrated perspective of basic health services, as can be seen from the Delibera della Giunta Regionale E.R. 2128/2016, *Case della Salute: indicazioni regionali per il coordinamento e lo sviluppo delle comunità di professionisti e della medicina di iniziativa*.

⁴ The Piano Nazionale di Ripresa e Resilienza (PNRR) approved in July 2021 provided for 15.6 billion for Mission 6 Health, of which 2 billion for community houses alone.

⁵ My critical observations on the “Primula” vaccination pavilions were reported by many press outlets and the subject of parliamentary questions. Among the various sources, please refer to the OPEN article of February 2021, <https://www.open.online/2021/02/07/covid-19-vaccini-primule-no-grazie-i-padiglioni-di-arcuri-rifiutati-dalle-regioni/>

⁶ Of the 1,350 community houses envisaged in the PNRR, the Meloni Government decided in July 2023 not to build 414 of them, postponing other future and not well-defined financing. Mostly these are ex-novo interventions with a higher construction cost. Source Agenas – Ministero della Salute, al 15.01.2024.

⁷ Project financed under the Programma Nazionale di Ripresa e Resilienza, Missione 04 Istruzione e ricerca – Componente 2 Dalla ricerca all’impresa Investimento 1.5 – Next Generation EU, Avviso n. 3277 del 30/12/2021. Gruppo UAL – Urban and



Architectural Laboratory of Department of Engineering and Architecture of the University of Parma - Prof. C. Quintelli (scientific responsible), Prof. E. Prandi (scientific co-responsible and research coordinator PNRR), PhD Arch. G. Verterame, Arch. A. Simbari, Arch. S. Taheri.

⁸ The research of the University of Parma sees, among others, the collaboration with Azienda USL, l'Azienda Ospedaliera Universitaria, e il Comune di Parma.

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Carlo Quintelli graduated from the Polytechnic of Milan with Guido Canella, and obtained a PhD in Architectural Composition from the IUAV, first cycle 1983-1985. Associate Professor at the Polytechnic of Turin, since 1998 he has promoted the birth of Architecture School in Parma of which he has been full professor since 2001. In 2004 he directed the first Architecture Festival in Italy. From 2013 to 2017 he was pro-Rector for UNIPR Building and Urban Development. Among the publications: *CittaEmilia: unique and multiple in linear urban form*, in AA.VV. *CittaEmilia – the Kent State Forum on the City*, Alinea Firenze 2012; *An urban gate for the University Campus in Parma's Oltretorrente District* in AA.VV. *IP Erasmus*, FAEdizioni Parma 2012; *The Abbey. An architectural project for the CSAC*, Il Poligrafo Padova 2018; *Ignazio Gardella. Other architectures*, with A. Lorenzi, Il Poligrafo Padova 2020, *The urban architectural design that structures the city*. In *The merged city* edited by P. Strina, Il Poligrafo, Padova 2023.

Enrico Prandi
**Compositional issues across the hospital type:
a critical itinerary.**

Abstract

Inserted within a research hypothesis on territorial medicine, this article deals with a rereading of the historical typologies of care spaces from their origins to the present day.

In this context, the hypothesis is formulated that the health house or community house being built, the local territorial health facilities provided for by Italian legislation and strengthened by the PNRR (National Recovery and Resilience Plan), require “architectural care” in order to increase the quality of the spaces, internal and external, as well as the external appearance.

In analogy to what happens in school buildings in which the space is defined as a “third educator”, we here criticize the definition of “space that heals” understood as an element that facilitates well-being by promoting healing processes.

Keywords

Hospital — Architectural type — Health architecture

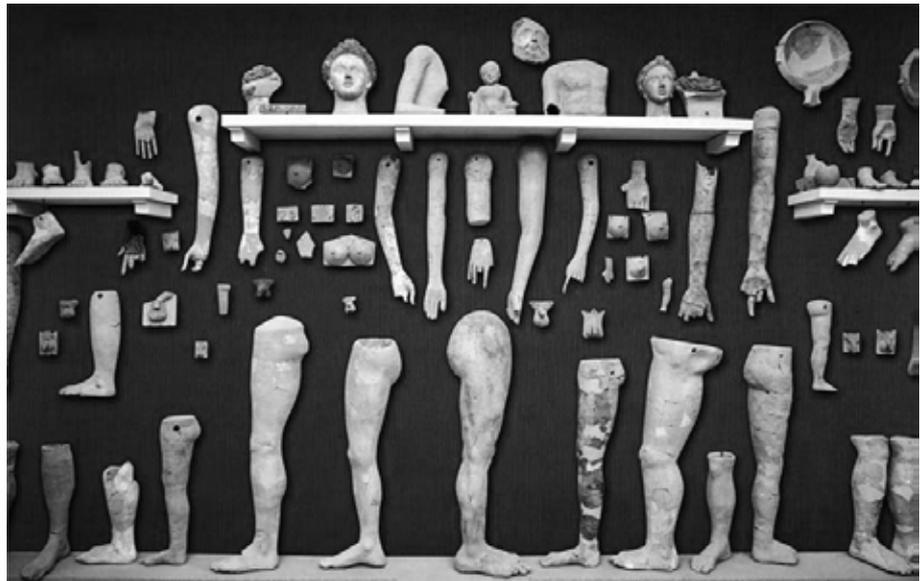
Premise

This text can only start from afar, from the ancient “places of care” that have led to the progressive rationalization of the spaces of current health understood as perfect and efficient “machines for healing”: not only and not so much, therefore, an architectural history of hospitals, but of the spatial typologies that have fulfilled over time the task of “assisting and curing” in its various forms (from the care of the spirit and mind even before the body). If we were to imagine a representation of the evolution of the care space up to today’s orientations of decentralized medical care, it could be a circle: from the original hybrid place (the nave room borrowed from the church) we are progressively oriented towards a large functionally rational and specialized organism, the Foucaultian one of the clinic, and then return with territorialized health care to multifunctional typologies to be reinvented. In this evolutionary process, the type of the place of care, except in rare cases, has literally expelled from design the architect responsible for the typological reinterpretation to rely on a rational, functional, engineering conception that led to the great complexes of the second half of the twentieth century.

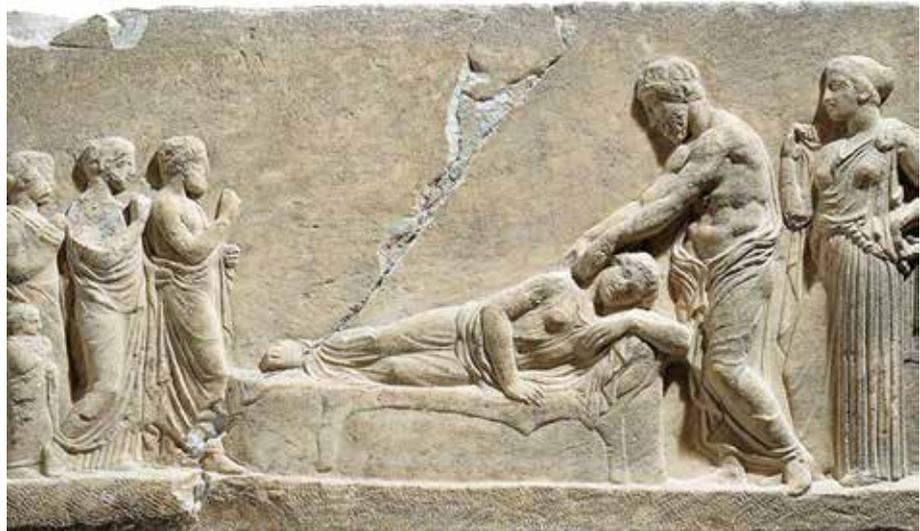
The spread of territorial and proximity medicine, relaunched by the crisis of hospital-centric health systems that occurred with the Covid-19 epidemic, has provided the reasons and tools for a rethinking of basic health facilities with a view to first care, the so-called Health Houses more recently evolved into Community Houses with the addition of social assistance. Multifunctional organisms par excellence that have their *raison d’être* in the creation of an integrated system of functions (medical, social, health and welfare). As architects, it seemed to us, then, an opportunity to regain that ‘lost space of architecture (and of the architect) of typological reinterpretation’ starting from the most significant historical examples collected here.

Fig. 1

Terracotta reproductions of anatomical parts offered as votive offerings to Asclepius.

**Fig. 2**

Asclepius and Hygieia (right), Piraeus Archaeological Museum, Athens.



From the *Asklepeion* to the Community House: for a complex and integrated notion of care

There is no doubt that the history of the typology of the space of care has followed the evolution of medical technique, science and culture, so much so that from the priest healer, the definition of the specialist doctor corresponds to a progressive spatial organization divided into specialized areas that leaves little to typological invention.

In the cities of ancient Greece, where the architectural typologies are the result of collective rites, the *Asklepeion*, generally located outside in a sort of holy 'other-city' (the sanctuary defined by the sacred enclosure), places the Temple of the God of Medicine Asclepius in a central position, surrounded by elements typical of the public spaces of the agora such as the long loggias (stoas that contain the cells of the sick). It was only after the third and second centuries B.C., however, that the places of hospitality were configured as the result of the relationship between the method of treatment and the space used for medical assistance through the creation of rooms reserved for the sick. Not yet a real hospital building but an articulated place in which the different elements such as the wood, the spring, the temple participate in the ritual of healing. Significant are the Asclepei of Epidaurus, Pergamon and Kos of the fourth century B.C. In the case of Epidaurus, the *Asklepeio* is part of a composite system distributed within the sacred enclosure that includes the dormitories, the Altar and the Tem-

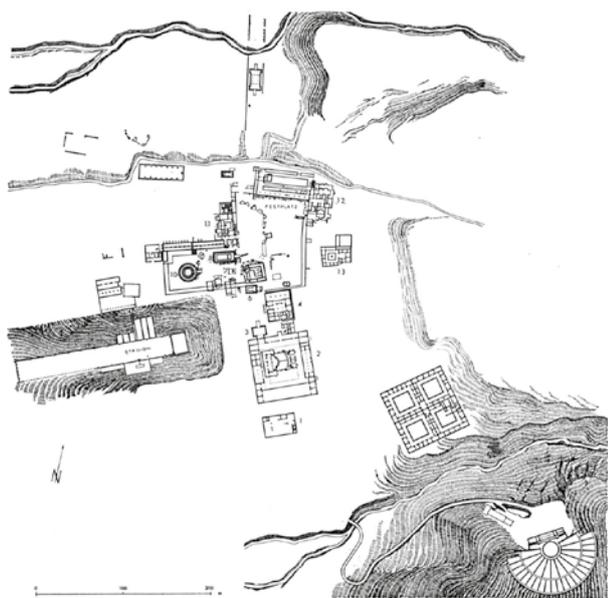
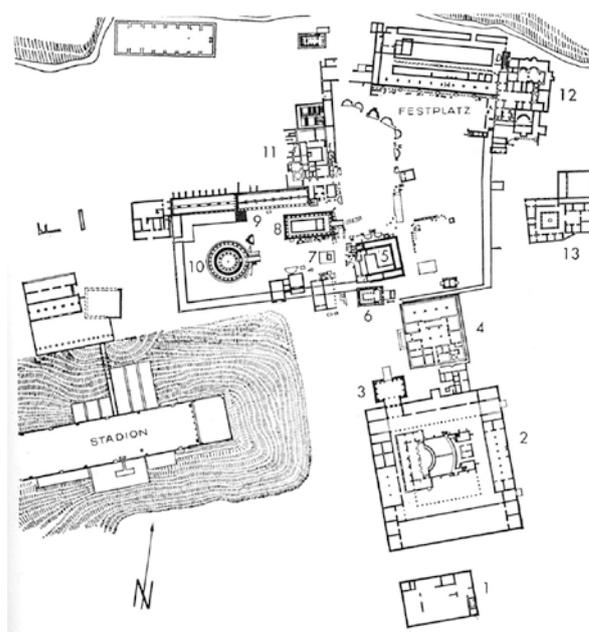


Fig. 3-4
Asklepeion of Epidaurus, 4th century BC. Plans



Legend

1. Bath (Greek period)	8. Temple of Asclepius
2. Gymnasium with the Odeon (Roman period)	9. Abaton (room for the healing sleep of the sick)
3. Propylaeum	10. Tholos
4. Youth dormitory	11. Roman baths
5. Dormitory for the elderly	12. Roman baths
6. Temple of Artemis	13. Sanctuary of the Egyptians (from the Roman era)
7. Altar of Asclepius	

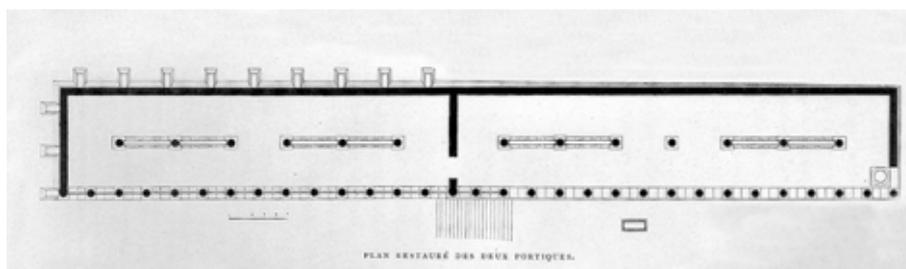


Fig. 5
Plan of the Abaton of Epidaurus, 4th century BC

ple of Asclepius and the *Abaton*, that is, the space (a two-storey portico) for the healing sleep of the sick. In the case of Pergamon, on the contrary, the *Asklepeion* is isolated and separated from the concentration of public functions to form “an urban architecture of complete form as a superimposition of continuous additions that follow or have in mind a general design” (Aymonino 2005). In the last case, that of Kos, the *Asklepeion* takes the form of an ascending path organized on two large courtyards and three terraces: the first, at the bottom, contained the rooms of the sick, the second terrace contained the Abaton and the two Temples dedicated to Apollo (the father) and Asclepio (the son) while the third terrace was dominated by the large Altar dedicated to Asclepius.

It is interesting to note that the term hospital itself (which denotes the place currently dedicated to care) originated from a subsequent series of spaces formerly dedicated to hospitality, even before that to care. *Hospitalis* was, in fact, the part of the Roman house reserved for guests (*hospes*), i.e. the place where travelers were welcomed. The Roman domus often had a space for care, so much so that it became the model for the *Iatreo*, which had already established itself in Greek times as a domestic place for the care of the sick, the archetype of the modern clinic. If private care was exercised at the domestic level, public care was affirmed through the characteristic institution of the *Valetudinaria*, in the two declinations for slaves and soldiers, i.e. the two productive entities of Roman society. Each permanent

Fig. 6, 8

Pergamum, Plan of the Asklepeion, second half of the 4th century BC.

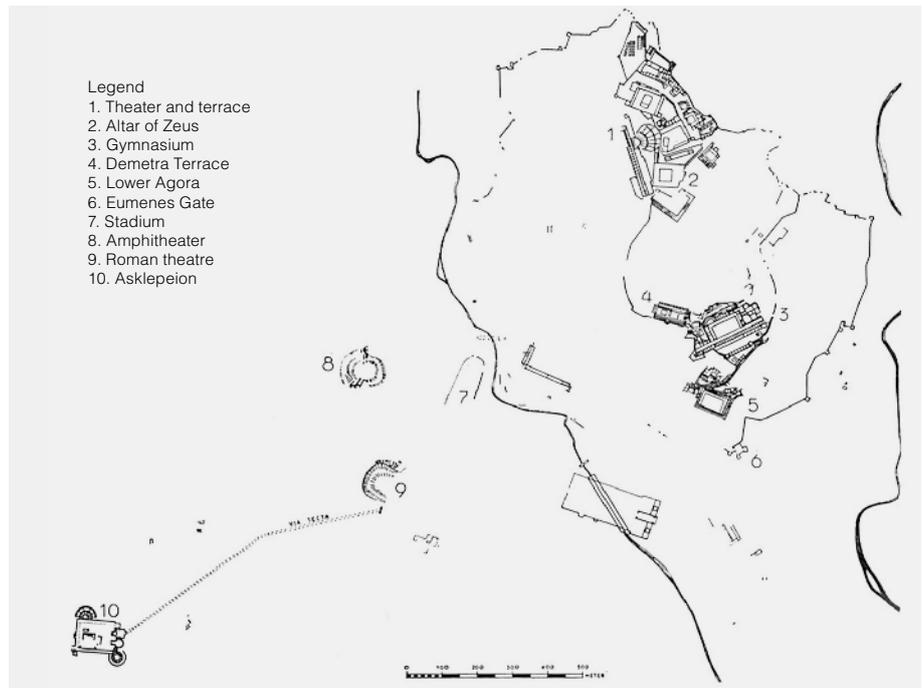


Fig. 7

Carlo Aymonino, Drawing of the Asklepeion of Pergamon.

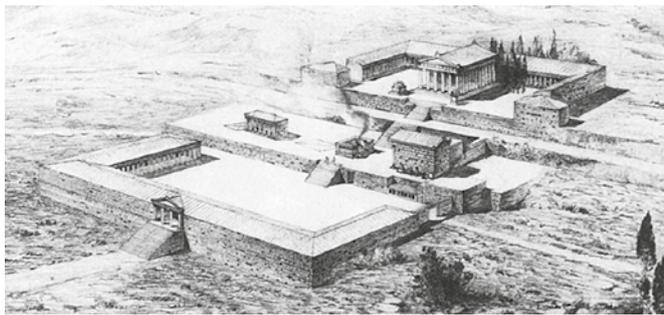
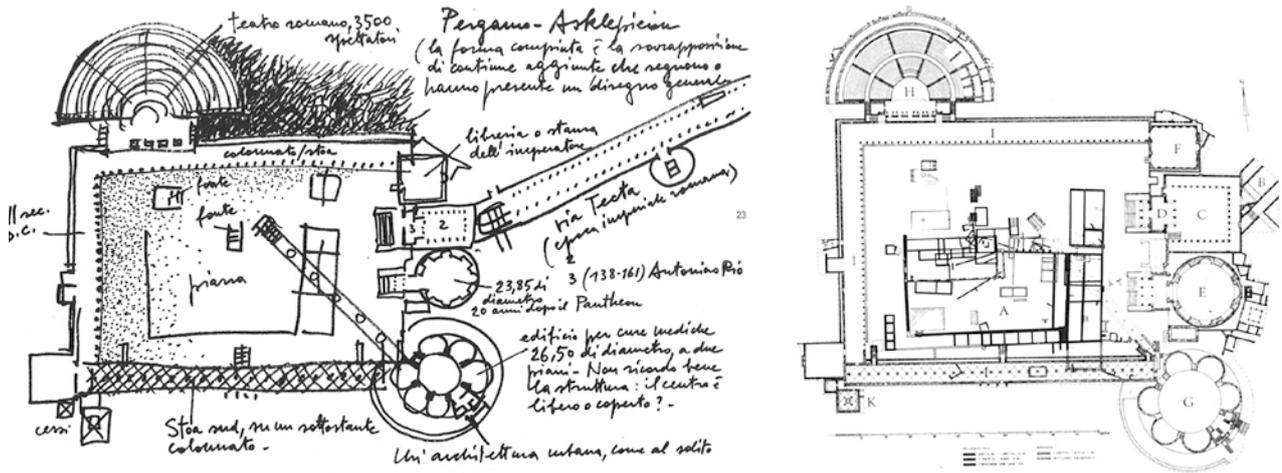


Fig. 9-11

Asklepeion of Kos, 5th BC-3rd AD
 Plan, reconstruction and section.

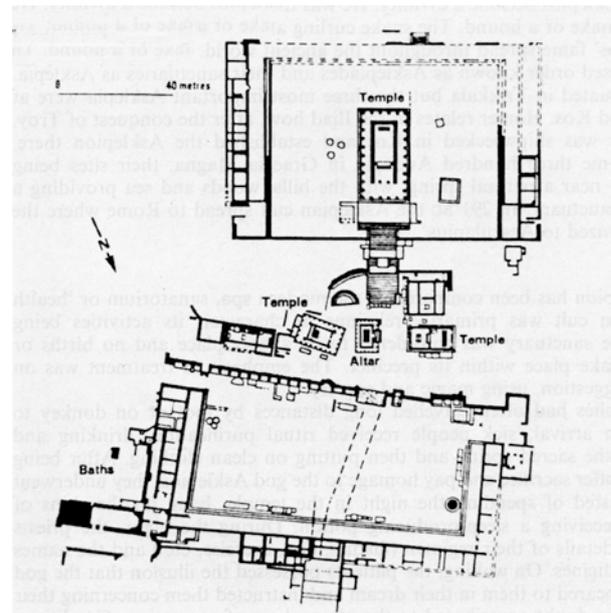
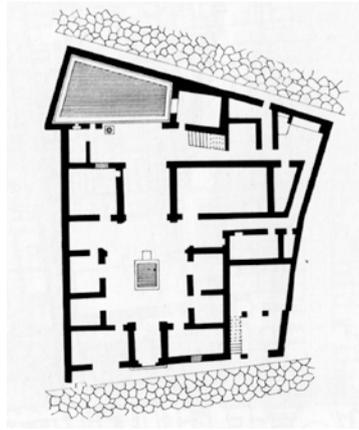
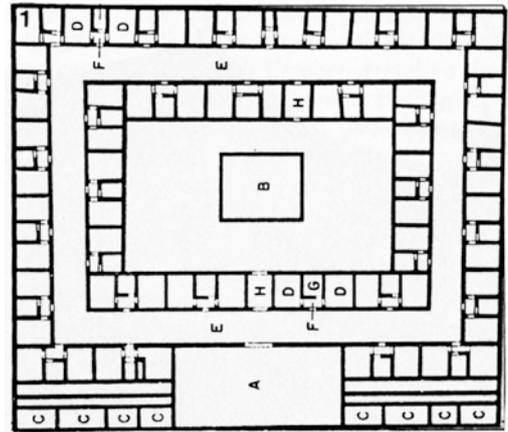


Fig. 12

House of the Surgeon of Pompeii. Iatroo, 4th and 3rd centuries BC.

**Fig. 13-14**

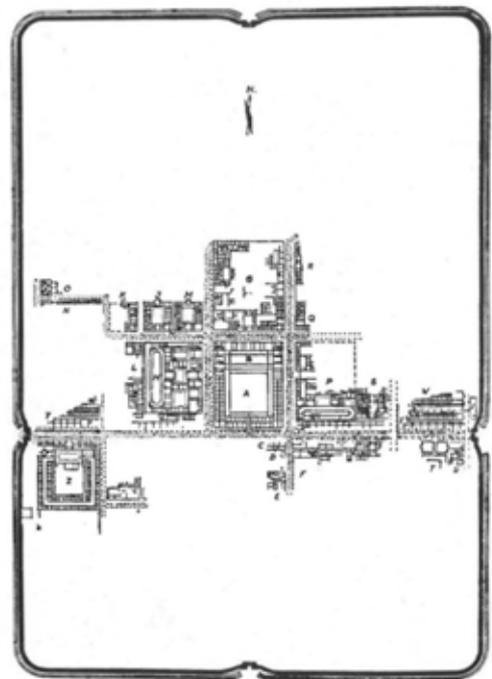
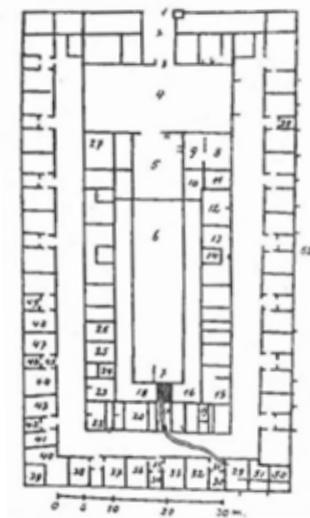
Plan and reconstruction of the Valetudinario of Vengadissa in Switzerland.

**Fig. 15**

Plant of the Valetudinario of the Castrum of Novaesium in Germany.

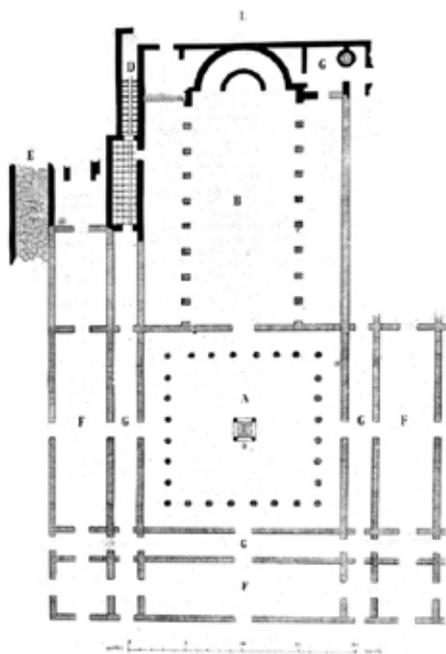
Fig. 16

Plant of Castrum di Vetera in Germany. The Valetudinario is marked with the letter "Z".



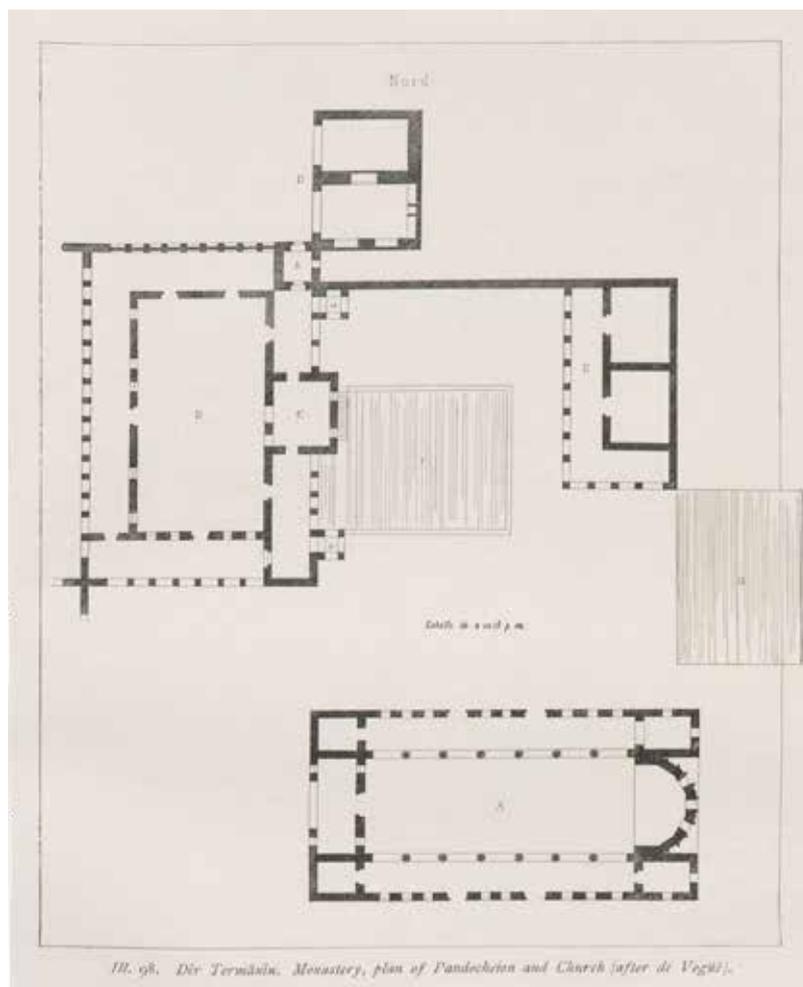
Roman camp had a military valetudinaria which, together with the Baths, the *Praetorium*, the *Quaestorium* and the *Gymnasium*, constituted the endowment of public buildings for the community (TABANELLI 1960). According to Roman practice, the *Valetudinaria* were mostly large square courtyards with a building distributed by a central corridor and the rooms arranged on both sides as in the case of Vengadissa in Switzerland and Vetera in Germany, while in some cases it could appear as an elongated rectangle court (Novaesium in Germany).

In the subsequent affirmation of Christianity, from 313 A.D., reception and assistance was incorporated into the institutional tasks of the Church and practiced above all in convent places and abbeys in large indistinct spaces. The formal passage took place with the Council of Nicaea in 325 A.D., which imposed the obligation for each city with a cathedral to establish a hospital directly connected to the church and directly managed by the clergy. The *Hospitolum* or *Hospitium* were in fact "hospitable places" where assistance and care were mostly given by men of faith and not by men



Legend

- A. Courtyard with cistern
- B. Basilica
- E. Via Antica
- F. Hospital rooms
- G. Disengagement corridors



III. 98. Die Termanin, Mönastery, plan of Pandocheion and Church (after de Vogüé).

Fig. 17

Xenodochio of Pammatio in Ostia, 398 AD, plan.

Fig. 18

Xenodochio of Termanin (Syria), 4th century AD, plan.

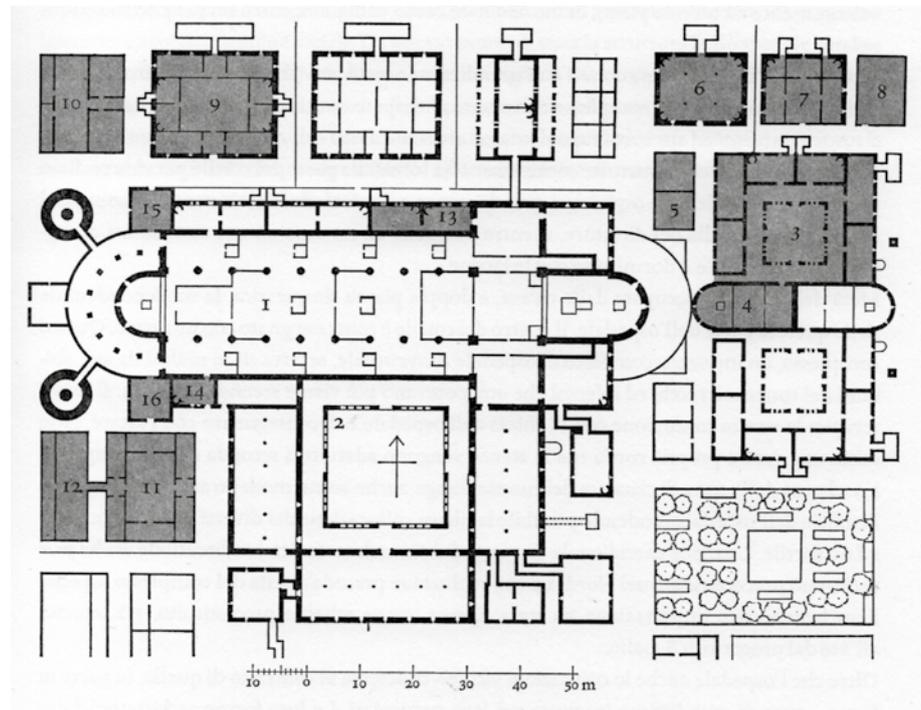
of science, even though it was empirical as it was at the time. Medicine, in fact, consisted of medicinal remedies, such as herbal preparations, and surgical remedies, such as bloodletting and incisions of various kinds. It is not surprising, therefore, that one of the oldest hospitals in the East, that of Caesarea in Cappadocia (present-day Israel), was founded between 368 and 372 A.D. by St. Basil, bishop of the city. Thus progressively the East came to equip itself with various welfare institutions such as gerontocomi, xenodochi, brefotrophs and hospitals.

In the West, the drive for the evangelization of beggars and pilgrims led in the Middle Ages to the construction of numerous *Xenodochia* located near the parishes on the main communication routes: however, they still do not have a precise typological reference due above all to the type of medical assistance that has not yet been scientifically defined. As an alternative to the Tabernea, run by lay people, the *Xenodochia* offered pilgrims places dedicated to meditation and healing and were arranged no more than 30-35 km from each other, the distance that could be covered in a day's walk. The first *Xenodochia* arose towards the end of the fourth century, as evidenced by that of Ostia (398 A.D.) which, despite its evident derivation from the temple, shows the characteristics of a greater articulation by virtue of the presence of a porticoed courtyard that precedes the Basilica and hospital rooms next to the court. In the case of Termanin in Syria, the two constituent parts of the structure are clearly separated: on one side the large hall surrounded by a portico while on the other the autonomous and separate basilica.

It is above all the religious orders – Benedictines, Cluniacs and Cistercians – who are responsible for the construction of the structures for the care of the sick, which cannot yet be identified as characteristic or characterized

Legend

1. Convent church
2. Cloister
3. Infirmary
4. Infirmary Church
5. Infirmary kitchen and bathroom
6. Environment for bloodletting
7. Doctors' House
8. Garden for medicinal plants
9. Home for distinguished guests
10. Kitchen, bakery and brewery for distinguished guests
11. Home for pilgrims and the poor
12. Kitchen, bakery and brewery for pilgrims
13. Homes for passing brothers
14. Administrator of hospices for pilgrims
15. Access to 9 and 11
16. Accesses to the 9th and the 11th

**Fig. 19**

Abbey of St. Gall, Switzerland,
c. 820 | redraw.

from an architectural point of view. In the convent or abbey typological organism, therefore, the spaces of assistance and care conform to the typology of the spaces of worship mostly with a linear development, with one or more naves, with the altar placed in a terminal position as required by the rule oriented towards the east. This is the case with the Benedictine Abbey of St. Gall in Switzerland.

The project was influenced by the dictates of reception and assistance inherent in the Rule of St. Benedict and included, within the medieval abbey complex, a hospital care system similar to the layout of the convent itself.

The abbey church separates the hospices, dedicated to any passing guests, welcomed in the entrance area and the hospital complex proper, located to the east. The main nucleus of the latter is arranged symmetrically around a minor church, the central axis of the project, equipped with a double altar, to allow simultaneous use by the sick housed in separate areas. The functional spaces are designed according to a precise division that separates them into places of hospitalization and care. On either side of the church, two cloisters connect two distinct and equal departments (men and women) organized with rooms, dormitories, latrines, rooms for the sick, contagious and related services: refectory, meeting space and overseer's quarters. The rooms for general services, kitchen and bathrooms, are separate from the wards and different for each department. The facility is completed on one side by the cemetery, on the other by the bloodletting buildings, pharmacy, room for serious cases, the doctor's quarters and the medicinal herbs garden. (LI CALZI 2008, 63).

In this period it is possible to identify two invariant elements from which to borrow the hospital: the church and the cloister. Thus the typology of the Gothic church offers itself to the interpretation of a single large hospital room (with one or three naves) with windows open on the long sides, while the cloister becomes the container of the service spaces.

In the Benedictine Abbey of St. Augustine of Canterbury in England, the infirmary was added using the small courtyard (little choister) as a joint. It consists of a rectangular hall and 3 naves of 75 x 21 m. The convent of Cluny in France also obeyed substantially the same rules, so much so that in the twelfth century an extension added the new infirmary consisting of a large room divided into three naves (55 x 27.5 m), connected to the old infirmary through a square cloister.



Fig. 24
Hôtel-Dieu, Paris. Depiction of a room in a 16th century print.

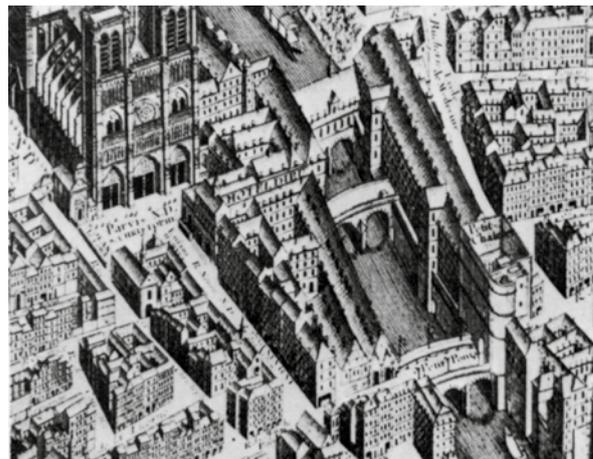
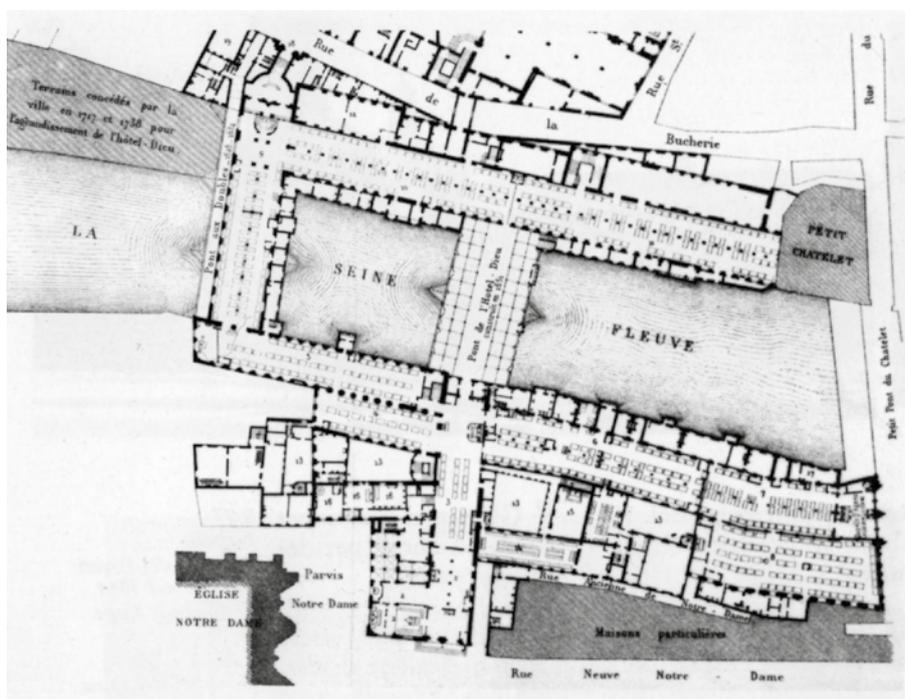


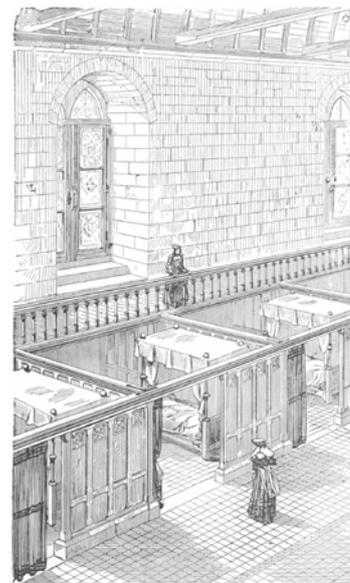
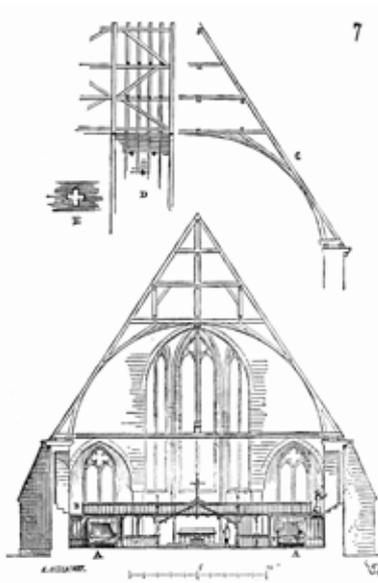
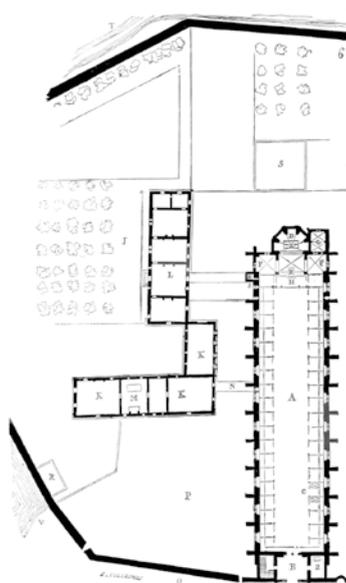
Fig. 25-26
View and plan of Notre Dame Cathedral and the Hôtel-Dieu before the fire of 1772.



Cistercian abbeys are no exception and use the same model. In the abbey of Fountains in England there is an infirmary room with three naves of about 55 x 25 m which has the particularity of being a bridge over the stream, probably for reasons of hygiene and water supply.

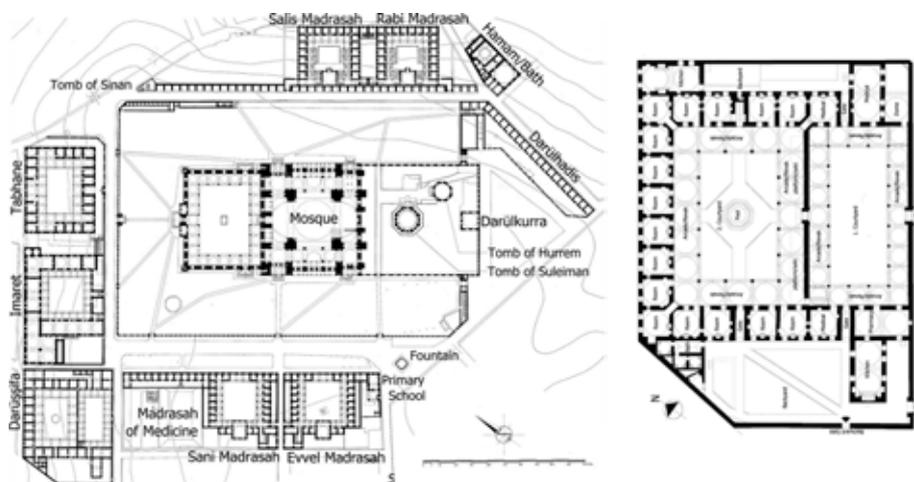
If, on the one hand, the complex self-sufficient convent structure had in the church-hospital the element dedicated to the care of the sick, on the other hand, the medieval city incorporated the hospital into the urban structure, in progressive and constant expansion, replacing, adapting and rewriting from time to time the spaces intended for services compared to the large hall of the sick. This is the case of the French Hôtel-Dieu and in particular that of Paris on the Ile de la Cité where the rooms with a single infirmary remain recognizable, gradually added to the point of saturation of the urban spaces and forced to expand beyond the Seine by means of bridges built for use as infirmaries.

At the same time, the discipline of medicine was progressing rapidly in the East, giving rise to hospitals typologically borrowed from the type of the royal palace, in which for the first time there is also the Medical School, as in the case of the al-Mansur Qalawun Hospital in Cairo in the thirteenth century. At the basis of this different typological paradigm there were the



Figg. 27-29

Eugène Viollet-le-Duc, *Dictionnaire raisonné de l'architecture française du XIe au XVIe siècle*, Tome 6, Hôtel-Dieu, 1868. Hôtel-Dieu of Tonnerre, late 13th century.



Figg. 30-32

Mimar Sinan, Suleymaniye Mosque Hospital, Istanbul, 1557.



Fig. 33

The al-Mansur Qalawun Hospital in Cairo, 13th century.



equally different medical-scientific beliefs not based on religious practice, so much so that it is precisely in the East, in continuity with the Greek tradition, that the medical discipline developed.

As part of the birth of the clinic, the school took on an increasingly important role until it determined a perfect symmetry between the two parts: hospital and school. Typologically, the porticoed courtyard becomes the matrix to be replicated for the organization of the various functions.

In Turkey, in particular, it is the buildings used for the hospitality of the poor and wayfarers, such as caravanserais, that provide a typology to be adopted for the development of the hospital. One of the first hospitals in Istanbul, the Suleymaniye is placed around the precincts of the Mosque along with the main public functions to build a

The typology of the courtyard, with protected passages for the use of separate hospital rooms, becomes functional to the care systems that evolve and are tested in direct contact with the patient. In this phenomenon, which was significantly secular, we can recognize the impulses that would determine the birth of the first hospital clinics in Europe only in the eighteenth century. (LI CALZI 2008, 84).

In the context in which this study is inserted, parallel to the development of the medical clinic, pharmacology also assumes particular significance based mainly on the use of simple herbs, grown in gardens intended as medicine gardens.

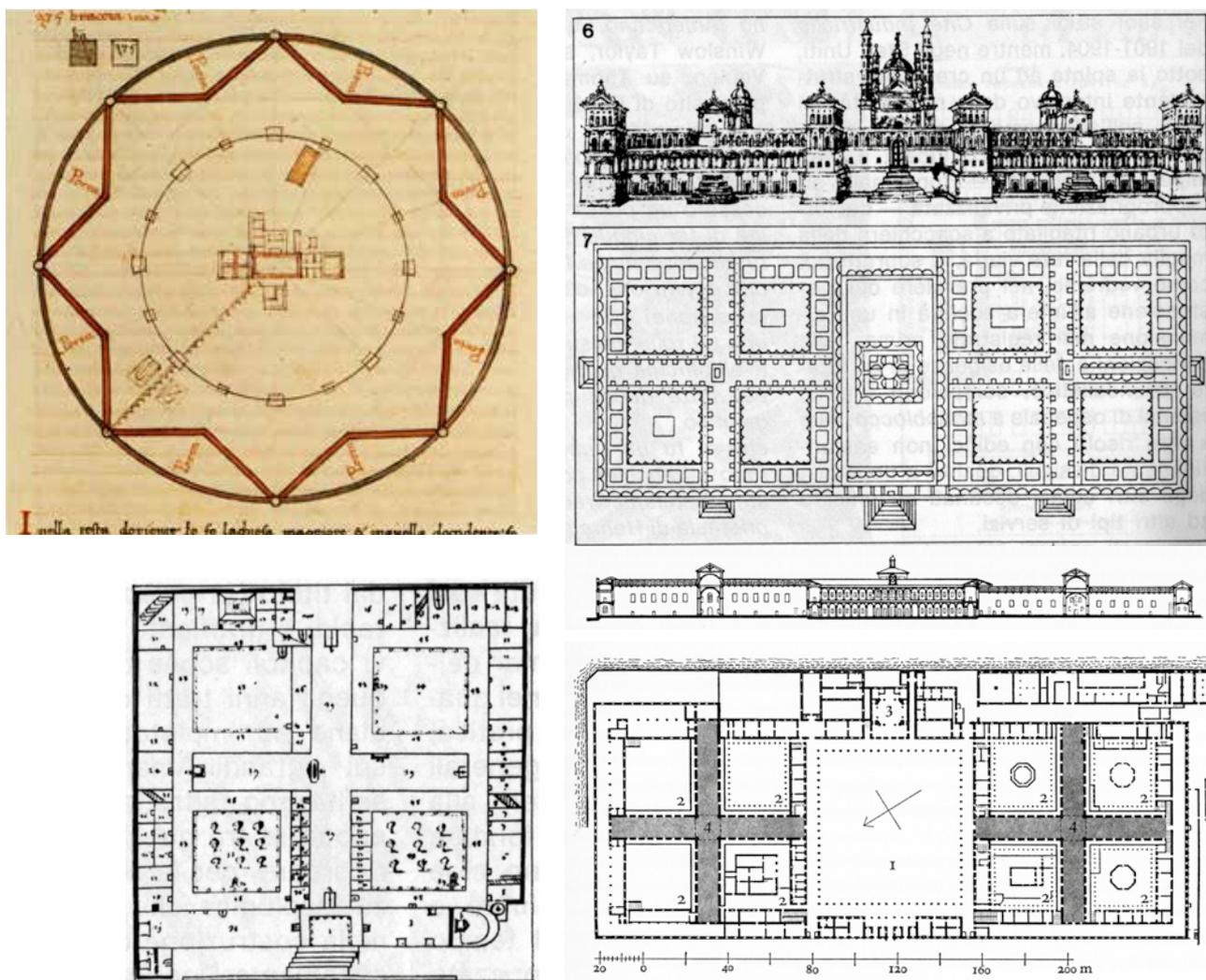


Fig. 34
Antonio Averlino known as Filarete, Sforzinda, 1460.

Figs. 35-38
Antonio Averlino known as Filarete, Spedale dei Poveri or Ospedale Maggiore (Ca' Granda), 1457.

Fig. 39
San Matteo Hospital, Pavia, 1449.

If the hospital-monastery turns out to be poleogenetic, giving rise to cities (as for example in the city of St. Gallen), the new fifteenth-century society imprints a renewal in the organization of the sick and in the management of the hospital even before the architectural typology. Users begin to be divided: the poor, wayfarers and pilgrims from the sick and the latter further divided by categories (the acute from the chronic, but also by sex): a modern complex now managed by secular power. We are witnessing the birth of an autonomous typology (the cross type) intended as a modern hospital factory. The highest example of a renewal that involves both the idea of the city and that of society (not without symbolic significance) can be found in the Ospedale Maggiore, the so-called Ca' Granda, in Milan, begun in 1456 by Antonio Averlino, known as Filarete. The latter had in fact placed the Hospital in the ideal city of Sforzinda alongside the great urban facilities such as the Palazzo del Signore, the Theatre, the Cathedral, the Market, etc.

As had already been the case in the past, the basic typological element consists of the courtyard: a large central courtyard, and four smaller porticoed courtyards, located on both sides, divided by as many cross-shaped bodies.

In the conception of the hospital there is a fundamental conceptual inversion: if the medieval hospital is the image of the church and the monastery, the Renaissance one, as a representative building of the new organization of the city's power, is the image of the civil palace and as such assumes its role and dignity.

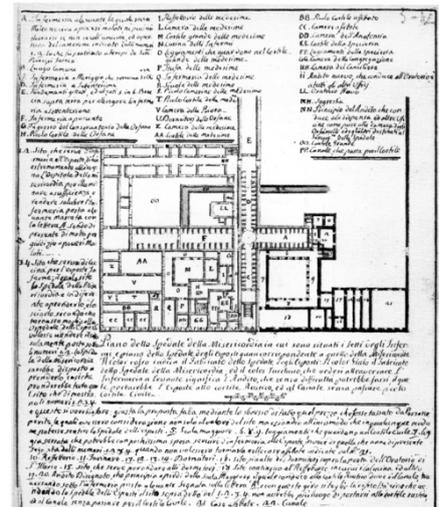
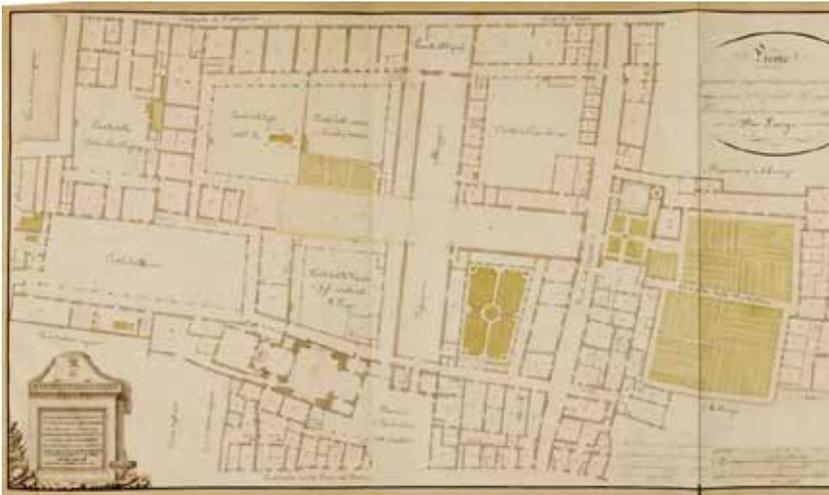
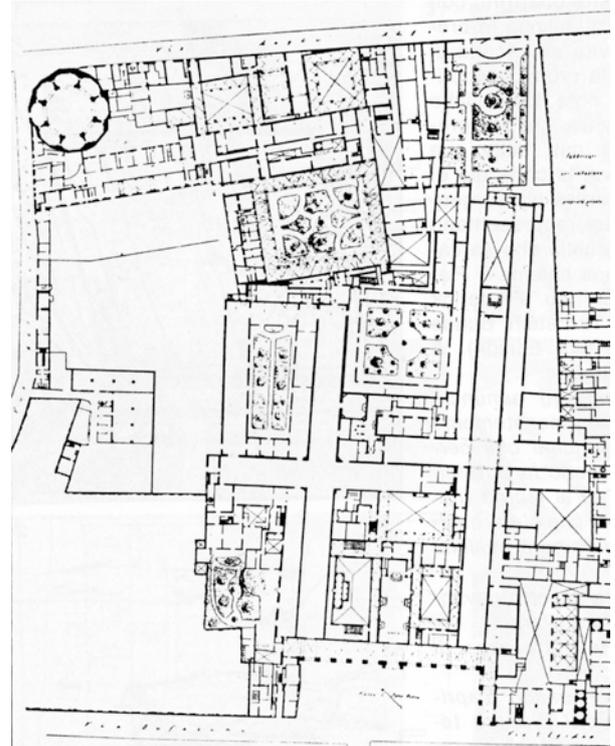
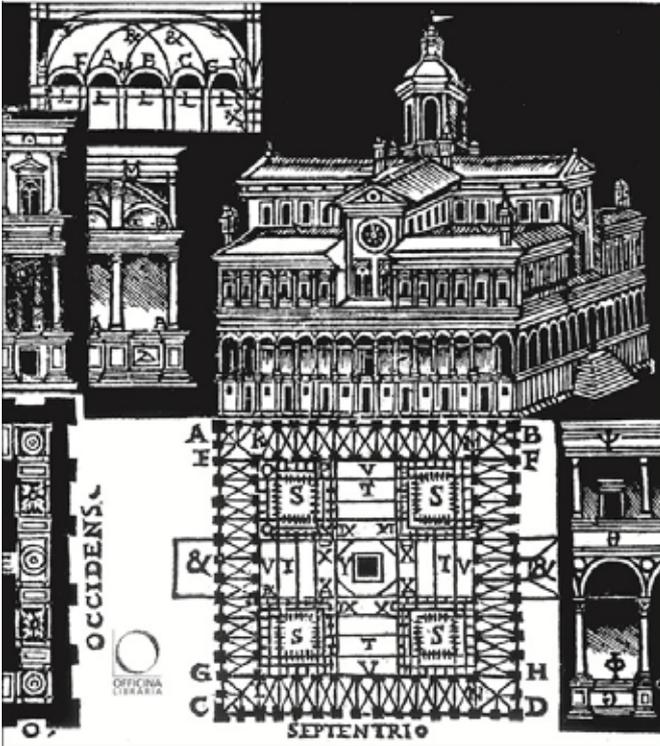


Fig. 40
The Hospital in an illustration from Cesare Cesariano's translation of Vitruvius' *De Architectura*, 1561.

Fig. 41
Santa Maria Nuova Hospital, Florence 1445.

Fig. 42
Crociera di San Luca, Brixia, 1447.

Fig. 43
Ospedale Vecchio, Parma, 1476.

So that in this new renewed setting it will be the church that will be incorporated into the hospital and not vice versa.

If the cross already appeared in Florence in the Hospital of Santa Maria Nuova (1445), Lombardy and Emilia were the territories in which it spread progressively and perfected: in Brescia (1447), Pavia (1449), Mantua (1450), Milan (1456), Lodi (1459), Como (1468), Piacenza (1471) and Parma (1476). The arrangement of the partly overlapping double cross of Florence gives way to a precise geometrization that is also consistent with the symbolic models of the Renaissance.

During the 1600s, there was a fundamental geometric reworking based on the combination of courtyards and crosses to determine a typological layout closed as an enclosure towards the city and above all autonomous. Towards the end of the century, a typological form began to appear, destined to have a certain success in the 1700s, consisting of the 'panoptic' radial scheme generated by the dual need to multiply the bodies while maintaining the functionality of the paths.

A subsequent typological change occurred with the appearance of the so-called Almshouses, i.e. residential welfare structures intended for the

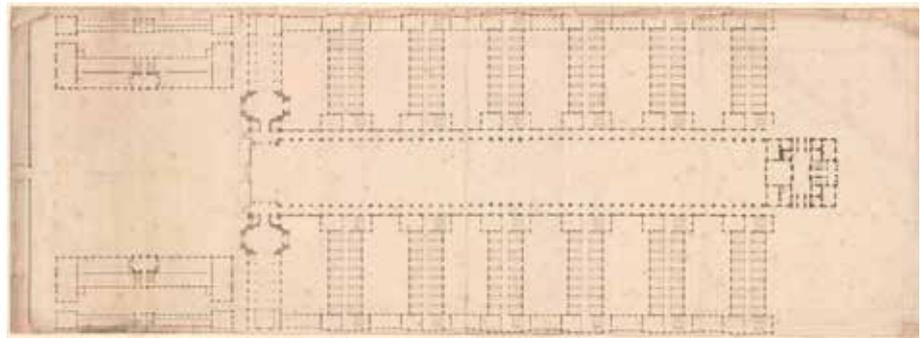
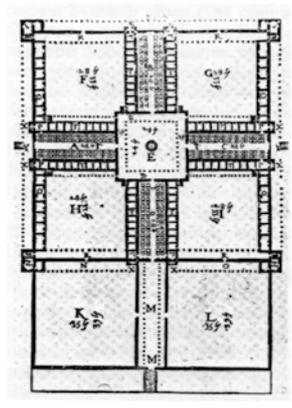
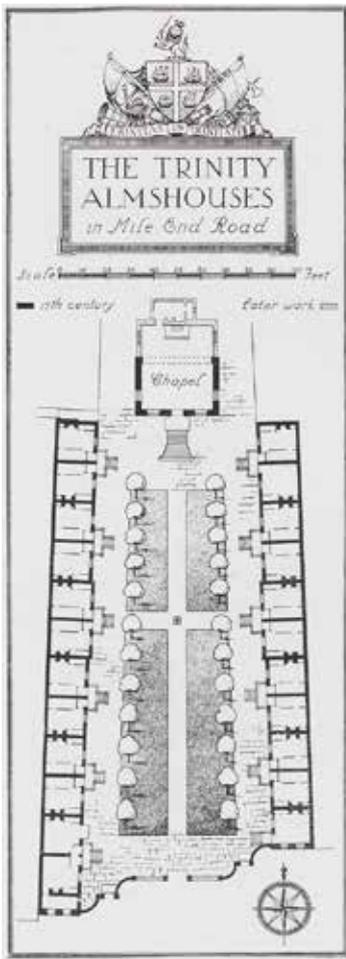


Fig. 44-45
The Trinity Almshouses, 1794.
Plan and view.

Fig. 46
Delorme Hospital, 1561

Fig. 47-48
Christopher Wren, Royal Naval Hospital, 1694-1702, Greenwich.
Plan and view.

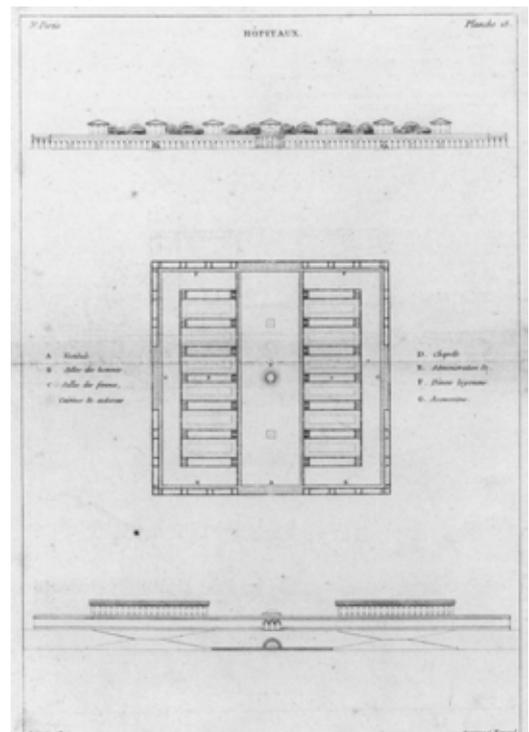
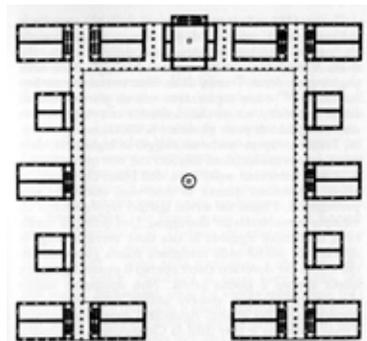


Fig. 49-50
Alexander Rovehead, Royal Naval Hospital, Stonehouse, Plymouth, 1758-1764.
Plan and view.



Fig. 51
Jean-Nicolas-Louis Durand, Hopitaux, Da Précis des leçons d'architecture, données à l'école polytechnique, Paris - 1802-1805.

poor that consisted of opposing linear buildings connected at the head on one side by a main body, resulting in an elongated open courtyard. This typology, later adopted in some British hospitals, was the archetype for another innovative type destined to be used also for other functions of associated life (e.g. university campuses) such as the parallel and isolated pavilion system. At first without any kind of physical connection, which will appear later, the square or rectangular pavilions were arranged on geometric planimetric schemes subordinated to an axis of symmetry at the end of which the main building was generally located. So was Christopher Wren's Royal Naval Hospital in Greenwich (1694-1702) and Alexander Rovehead's later Royal Naval Hospital in Stonehouse, Plymouth (1758-1764).

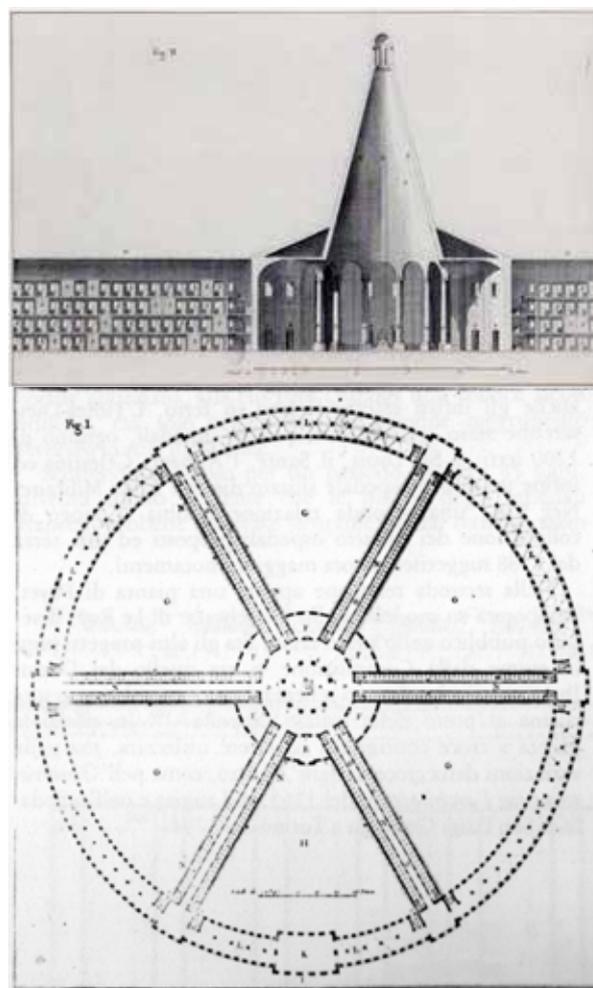
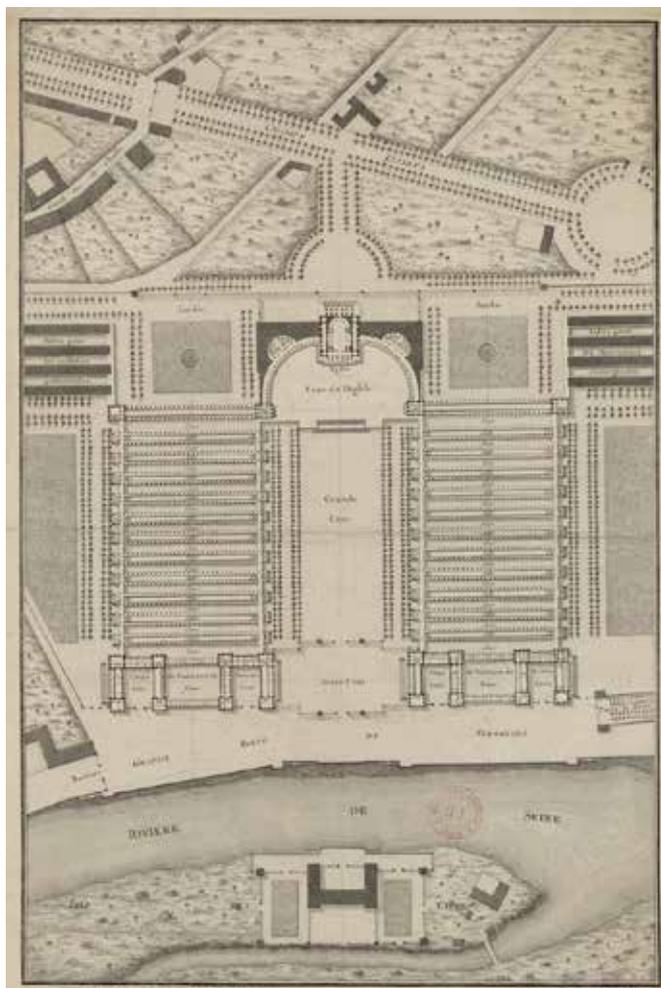
The competition for the construction of the Hôtel Dieu in Paris (1777-1788), following the fire of 1772, made a decisive contribution to the imposition of the pavilion hospital as a typological model for the modern hospital. The occasion of the competition of a hospital for a large city such as Paris was already at that time catalyzed the attention of the various disciplinary knowledge, contributing to a decisive advancement of knowledge in the medical, scientific and architectural fields. It is no coincidence that Michel Foucault (1976) defines them as "healing machines" that obey not only a formal aesthetic principle but a functional order: "the hospital-building is organized little by little as an instrument of medical action" (Foucault 1975). More than two hundred projects solicit the consciences of doctors on medical and scientific problems, giving rise to what he called the "birth of the clinic": "the architecture of the clinic is progressively defined by a series of controversies about the internal order, location, size, distribution and number of these new machines, designed to heal a large

Fig. 52

M. Le Roy, Plan général d'un projet d'Hôtel-Dieu, Parigi, 1773. Plan and view.

Figg. 53-54

Antoine Petit, Projet et mémoire sur la meilleure manière de construire un hôpital de malades, Louis Cellot, 1774. Section and Plan.



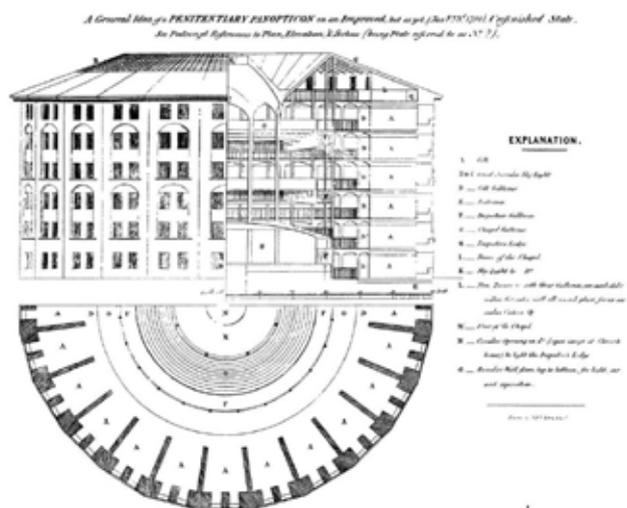
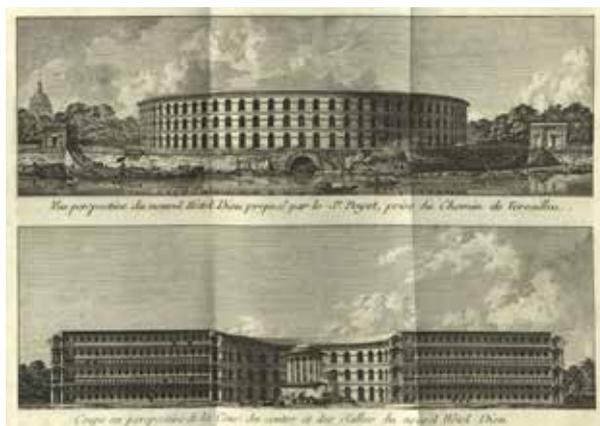
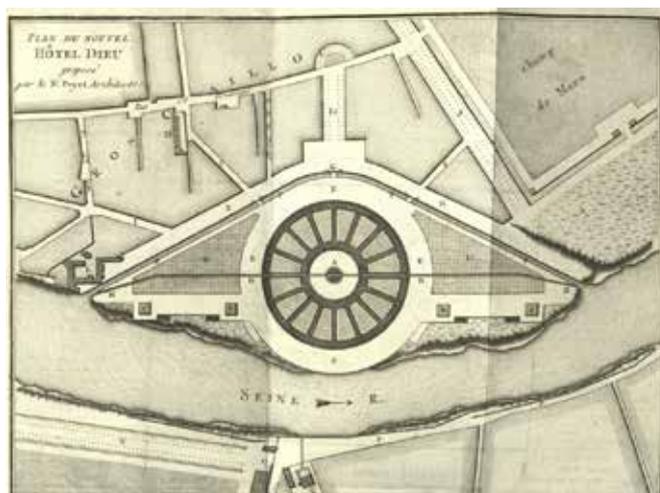
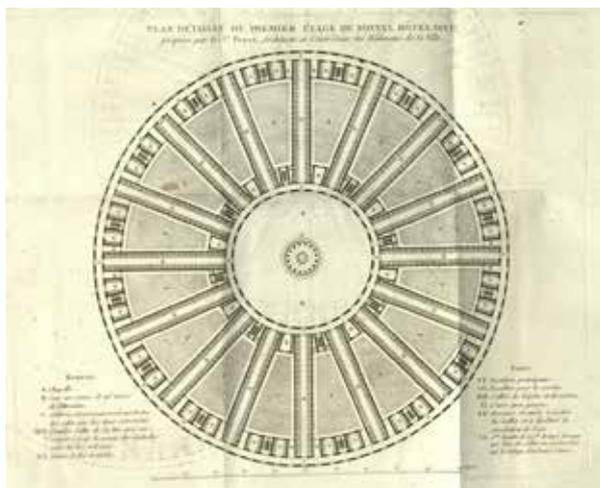


Fig. 55-57

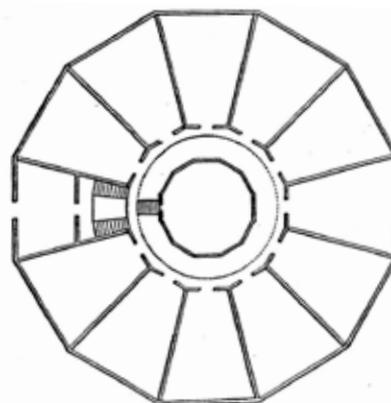
Bernard Poyet, Project for the reconstruction of the Hotel Dieu, Paris (first project), 1785. Plan, plan, elevation and section.

Fig. 58

Jeremy Bentham, A general idea of Penitentiary Panopticon, drawing by Willey Reveley in 1791.

Fig. 59

Jeremy Bentham, Panopticon, 1797.



number of patients in economy” (Foucault 1963).

In the encyclopaedic manualistic process that dominated the second half of the century (see Diderot and D’Alembert) the hospital entered to all intents and purposes as a protagonist on a par with large public buildings. However, it is always the sanitary concept of ventilation that justifies the adoption of separate and independent pavilions, which can therefore benefit from correct ventilation seen as a therapeutic tool. This is the case with the projects of the Hotel Dieu in Paris, such as the pavilion hospital by Jean Baptiste Leroy (1773), which refers directly to the type of the Royal Palace (that of Marly), which is characterized by a large rectangular courtyard on either side of which are the parallel and isolated pavilions that contain the patient rooms, while two separate courtyards contain the general services and administration. The layout is symmetrical and on the bottom of

Fig. 60-61

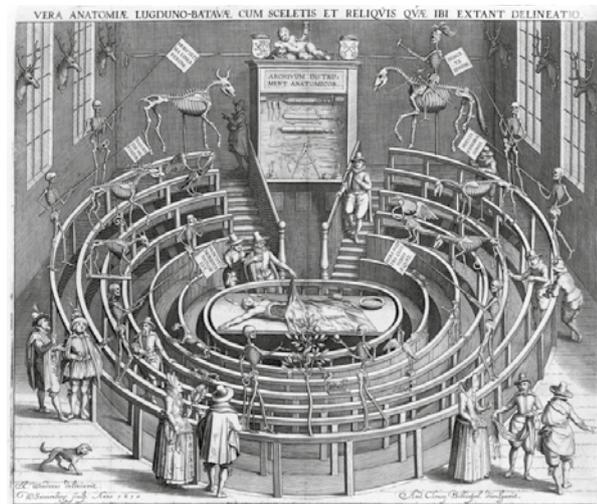
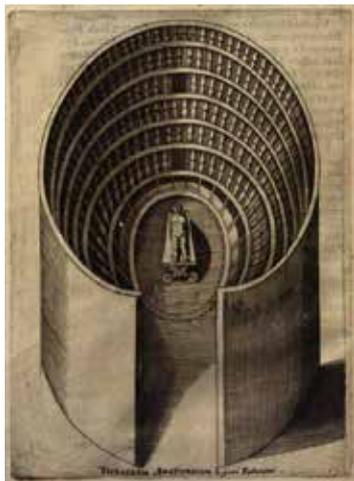
Anatomical Theater of the University of Padua, 1594-95. Drawing and photography.

Fig. 62

Plan of the Medical School of the University of Pisa, 1597.

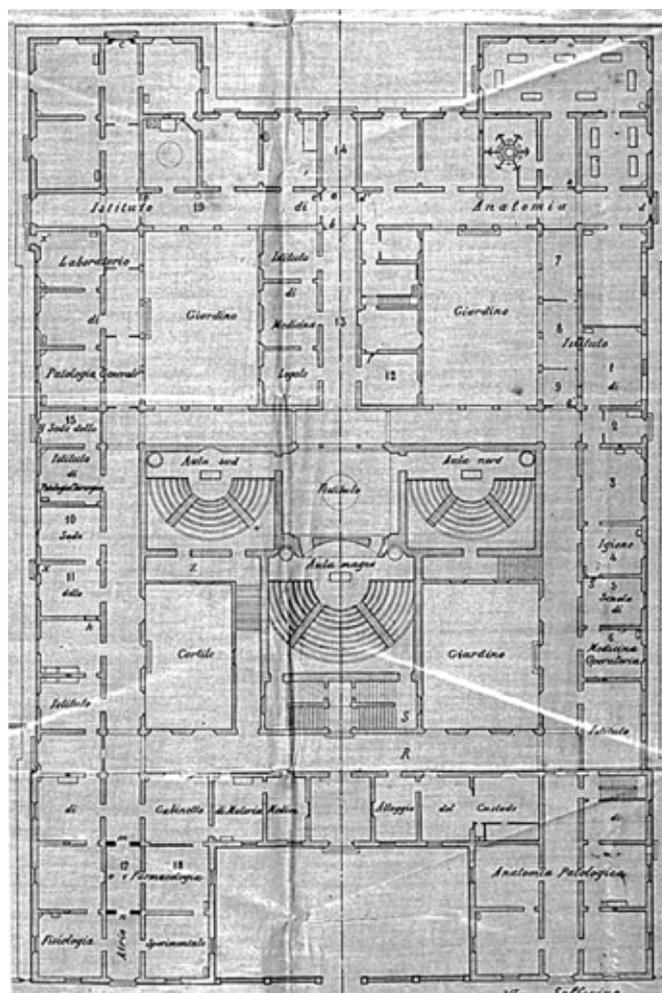
Fig. 63

Anatomical Theater of Leiden University, 1597.



the axis, there is an exedra portico with the church in a central position. A variant of the pavilion hospital is the Radial or Panoptic Hospital by Antoine Petit (1774). In this case, six long buildings are connected by an external circular courtyard, while at the central junction there is a round room with a chapel that culminates in a conical fireplace that becomes the main element of air exchange. It should be noted that the central position that has always been occupied by the religious function is now occupied by the fireplace in its important technological function. In Bernard Poyet's subsequent panoptic design (1785), the multiplication of the pavilions in a radial pattern, as many as sixteen, imposes a minimal variation in the central space, no longer symbolically occupied by the full chimney but by the void of an open courtyard at the center of which is a religious temple. The latter project is substantially coeval with the Panopticon project by Jeremy Bentham (1785-1791), a prototype of a building designed to contain a school, a factory, a hospital or a prison, which will become the basis for the development of a whole series of theoretical demonstration projects developed during the 19th century for museum, social, etc. functions.

Although it appeared as early as the Renaissance, in nineteenth-century hospitals the anatomical theater or scientific theater also imposed itself, understood as the space of medical research and teaching that takes the form of an amphitheater with stepped seats facing the dissection table. Although it was originally configured as a typologically uncharacterized space, being mostly obtained in conventional rooms set up with wooden steps, it will have a fundamental importance for the purpose of an internal typological variation of the treatment spaces, which have now often also become places in which to impart the medical discipline. Alongside the treatment spaces, therefore, the typological spatial palimpsest will be en-



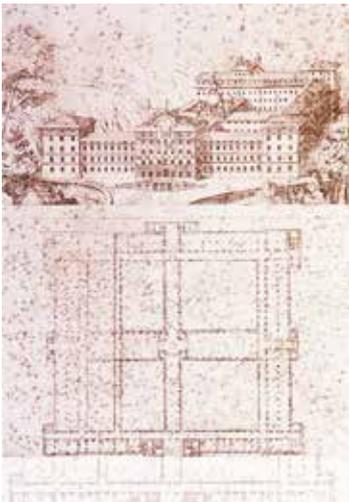


Fig. 64
Plan and elevation of the Albergo dei Poveri (Barabino plan), 1652

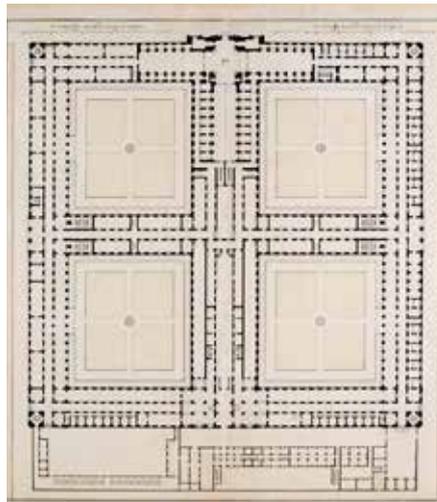


Fig. 65
Ferdinando Fuga, Albergo dei Poveri di Napoli, Second version, 1753.

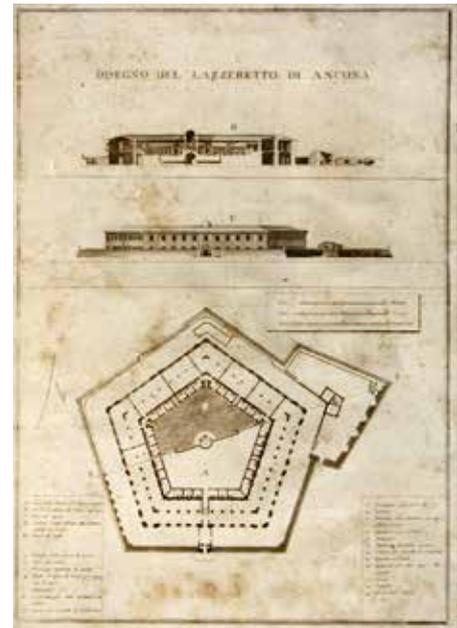


Fig. 66
Luigi Vanvitelli, Lazzaretto di Ancona, 1733. Section, elevation and plan.

riched with spaces in which to study diseases or make medical knowledge transmissible: classrooms, lavatories, laboratories, etc.

The typological evolution of the care and care spaces also contributes to the organisms created for specific categories of needy people as a modification of a principle (also scientific) that saw all types hospitalized in a single structure and often in a single space at most grouped by functional needs. Thus were born in Italy the Hospitals of the Incurables also intended for the insane, the syphilitic and in general the chronic, the Houses of San Lazzaro for lepers, the Lazzaretti for the contagious in the not infrequent cases of epidemics, the Hotels for the poor, born from the social need to save the unemployed from delinquency. Starting from the 1600s (which will be followed by the eighteenth-century reforms) the trend towards a more complex and structured organization of medical care will follow the same process of classification and subdivision of pathologies and a progressive different organization of medical knowledge in specific disciplines.

An interesting case in which medical assistance intersects with social assistance by sharing the typological structure is the experience of the English Workhouses also known as Poorhouses, a type of hospice for the poor born following the spread of the Black Death Pandemic of the 1300s and which had a typological evolution between assistance, control and possession distinguishing the characteristics of the plant. It is precisely in this progressive modification of social welfare needs, especially following the New Poor Law of 1834, that there is an increase in the debate, including architectural debate, with a consequent proliferation of architectural projects.

Thus it was that the architect Sampson Kempthorne, whose father was a friend of the head of the legislative commission, began to develop a series of Workhouse models: the first consists of a 3-storey cruciform plan enclosed in a low square body that delimits four internal courtyards divided between women, men, girls and boys. If the central cross-shaped part was reserved for residential functions, the perimeter body housed laboratories and shops that overlooked the inside of the courtyard while outside everything was bordered by walls. Organisms closed to the city, so much so that they earned the nickname of “pauper bastilles” (bastilles of the poor) that progressively adapted more and more to the model of the Benthamian panoptic, inspiring from a formal but also conceptual point of view the subsequent projects of hexagonal shape (with the central body in the shape of a Y) and octagonal radius. It is precisely this tendency towards

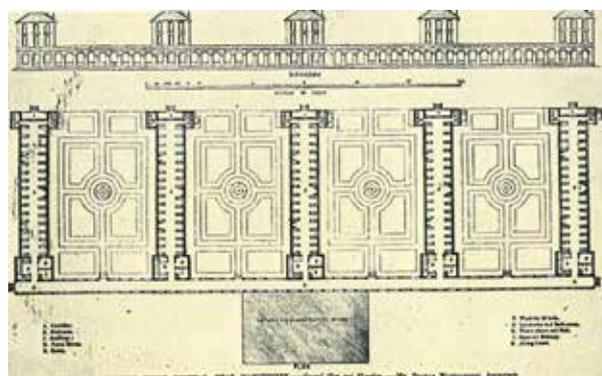
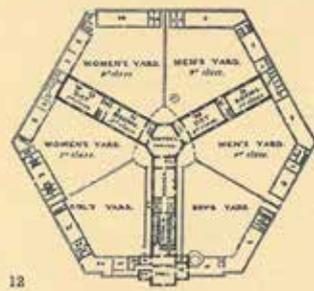
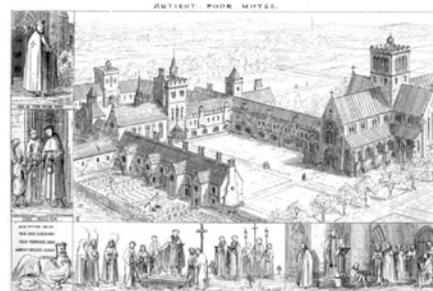
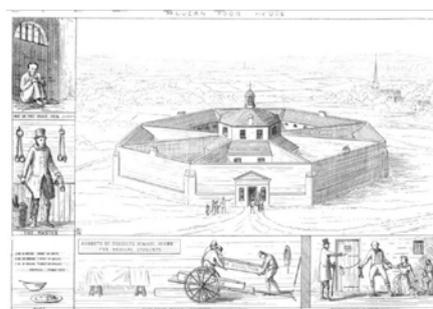
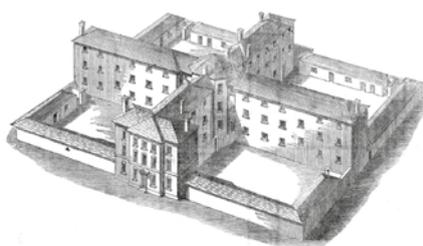
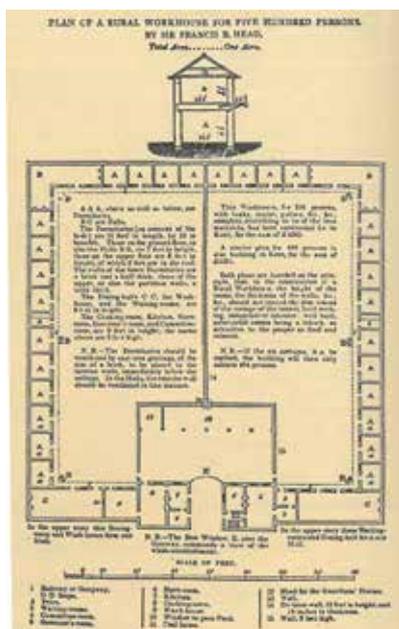


Fig. 67
Francis Head, Model Plan for a Rural Workhouse designed to accommodate 500 Paupers, 1835.

Figs. 68-69
Sampson Kempthorne, Design for a Crosswork Workhouse, 1835. Axonometry and plan.

Fig. 70
Augustus Welby, Comparison of Ancient and Modern Workhouses, 1836.

Figs. 71-72
Sampson Kempthorne, Design for a Hexagonal Workhouse, 1835. Axonometry and plan.

Figs. 73-74
Thomas Worthington, Chorlton Union Workhouse Infirmary, 1865.

the conceptual model, containing and reclusive of the panoptic, that earned Kempthorne's projects the fiercest criticism, so much so that he was harshly attacked even through a criticism that nowadays would be called comparative.

Progressively, the typological model adopted shifted towards the more classic pavilion type, often used as an extension of existing workhouses, as in the case of Manchester, in which the additional body of the infirmary, consisting of five linear pavilions with three floors forming a comb, are connected to the ground floor by an open portico.

With the spread of nineteenth-century manuals, even in Italy the pavilion hospital was taken as a model and developed, perhaps by virtue of a more limited demand for seats, according to a typological variant that sees the pavilions coupled and replicated in parallel while the central courtyard replaced by a porticoed path or alternatively a single linear connecting bu-

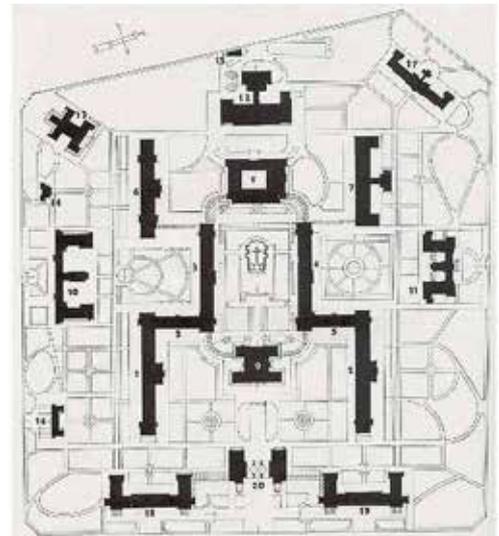
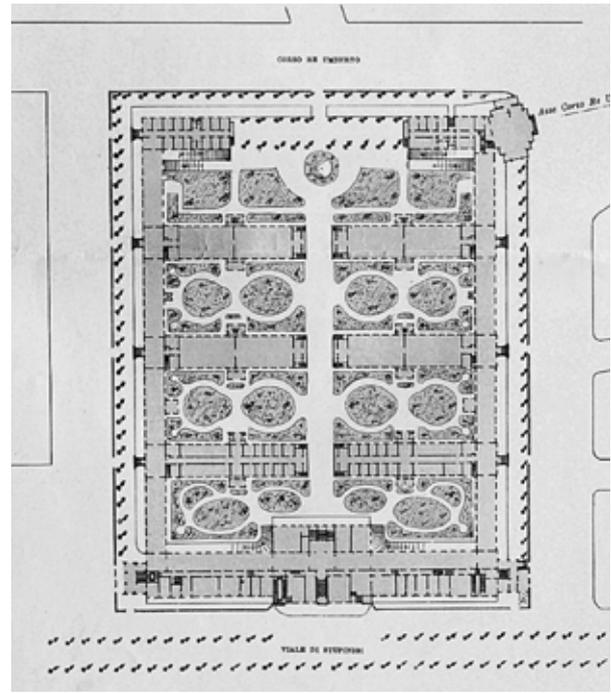
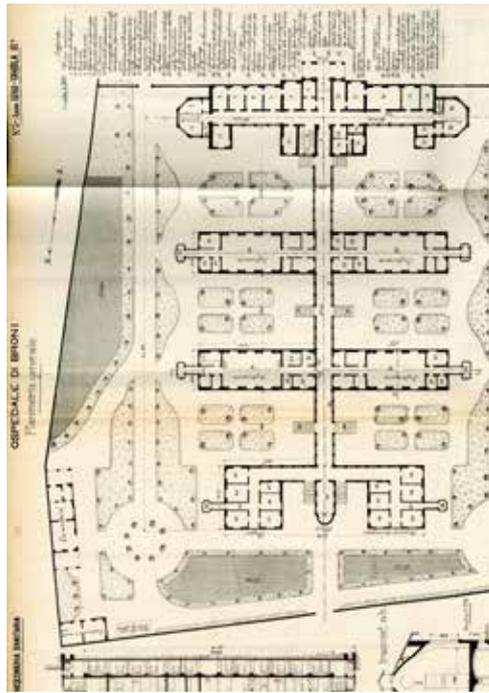


Fig. 75
Febo Bottini, Carlo Arnaboldi
Gazzaniga di Broni model ho-
spital, Pavia, 1889-90

Fig. 76
Ing. Ambrogio Perincioli, Ospe-
dale Mauriziano, Turin, 1881-85

Fig. 77
Emanuele Caniggia, Forlanini
Hospital, Rome, 1934.

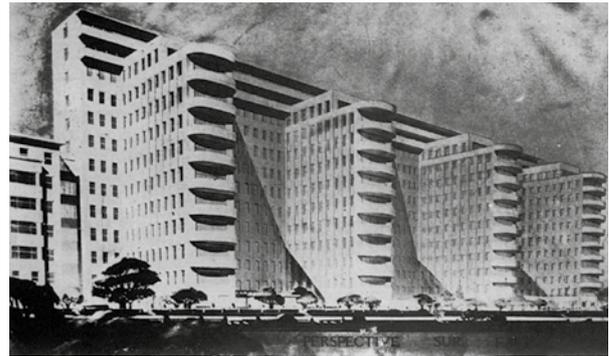
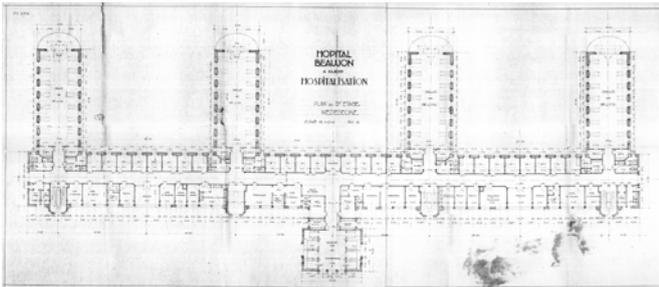
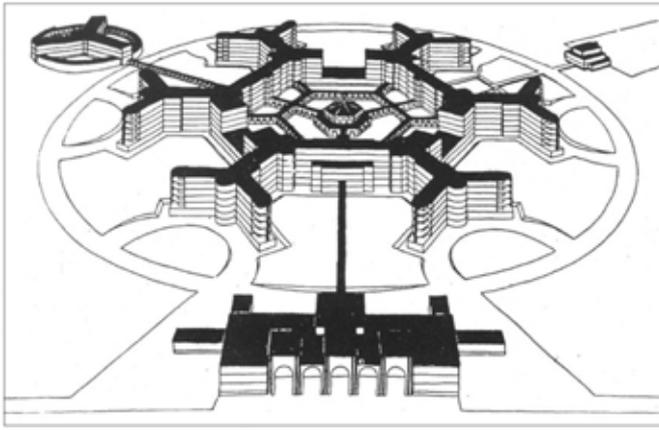
Fig. 78
Giulio Marcovigi with Giulio Ulis-
se Arata, Niguarda Hospital in
Milan, 1939.

ilding that distributes to the pavilions on both sides. The model hospital of Andrea Busiri, an academic professor of San Luca published in a study of 1884, and the hospital of Broni by Febo Bottini of 1889-90 are examples of these two typological variants.

Between the 1800s and 1900s, the pavilion model underwent geometric adaptations and changes in scale, also through the increase in the green area, which often contributed to defining it as a “garden-hospital”, until it reached mixed typologies as in the case of the Forlanini hospital in Rome by Emanuele Caniggia (1934) or the Niguarda hospital in Milan by Ing. Giulio Marcovigi with the contribution of Giulio Ulisse Arata (1939).

The link between the pavilion hospital and the monobloc hospital, which constitutes the subsequent typological model of modernity, is constituted by the project of the Brescia hospital by Ing. Angelo Bordonì (1938), a typological hybrid that combines the idea of the block hospital with the idea of pavilions. A hexagonal courtyard, in turn divided by six radial connecting paths, connects at the vertices to as many Y-shaped buildings. Three central axes distribute from the body of the separate entrance to two other external bodies.

The proto-functionalism of the Brescia hospital (designed not by chance

**Figg. 79-80**

Eng. Angelo Bordonì, Brescia Hospital, 1938. Perspective and photography from above.

Figg. 81-83

Jean Walter, Urbain Cassan & Louis Victor Plousey, Beaujon Hospital, Paris, 1935. Perspective and photography.

by an engineer) will give way to Fordist functionalism that sees the rationalization of the paths (horizontal and vertical) as the most important aspect. The monobloc will grow above all in height (from 4/5 floors up to 12 or more in America) and will impose itself in the urban body more in the unitary and heavy mass than in a typological articulation.

The monobloc type, to which the polyblock type will be added, matures as a result of scientific, medical and technological developments (the latter not dissimilar to those that led to the imposition of the skyscraper type) and can be considered as a development in height of the pavilion principle. An example of this typology can be taken from the Hôpital Beaujon in Paris of 1935 by Jean Walter, Urbain Cassan & Louis Victor Plousey, in which the planimetric layout formed by 4 wings connected by a transversal body is replicated for almost 10 floors to determine a complex of considerable architectural mass.

Apart from a few exceptions, on the threshold of Rationalism, the hospital became the field of engineering design (from individual engineering specialists such as Marcovigi to today's engineering companies) with the architect who, when present as in the case of Giulio Ulisse Arata in Niguarda, intervened on the aesthetic aspect but not on the typological one. In the same period, however, the parable that goes from the discovery of care to the definition of the environments for the treatment of sanatorium diseases provides rationalist architects with a typology to be invented and interpreted according to the canons of modern architecture.

If, on the one hand, hospital specialization excludes architects from hospitals, on the other hand, the invention of health facilities and specific treatment centers such as anti-tuberculosis dispensaries (Gardella, Ales-

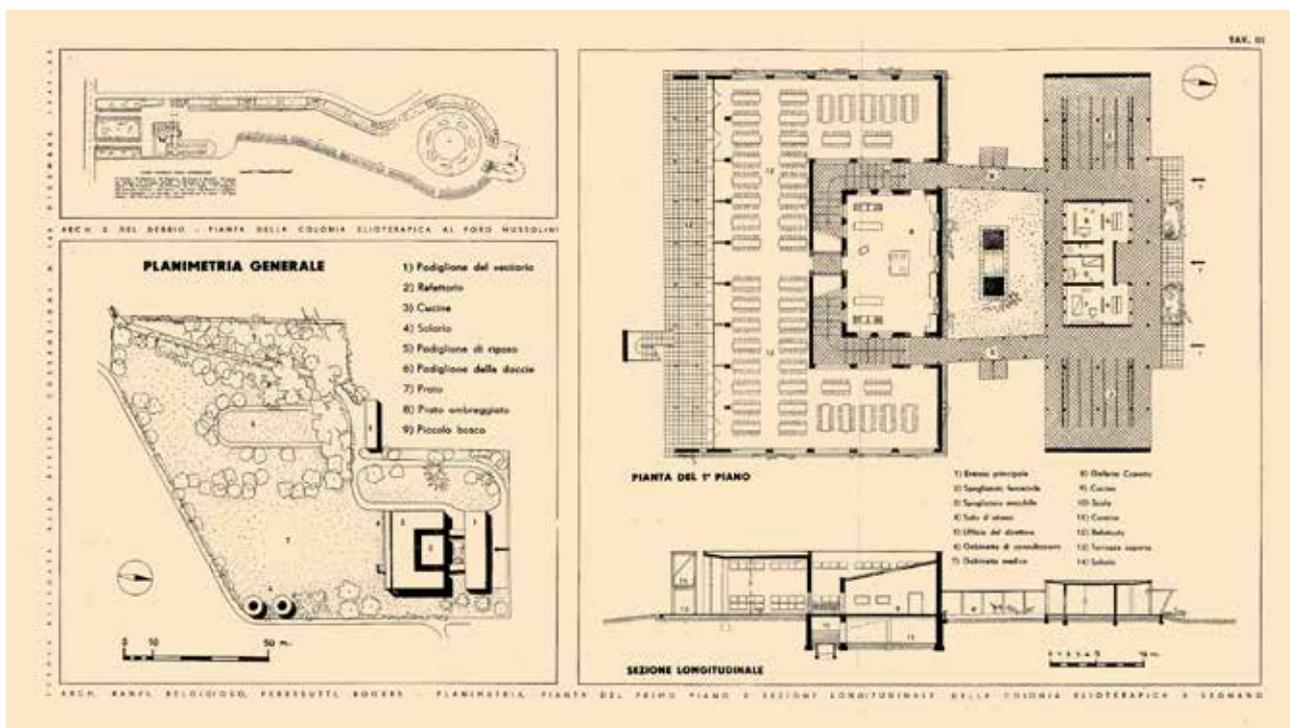
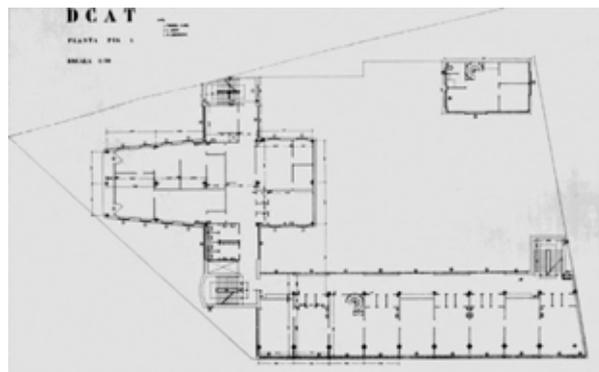
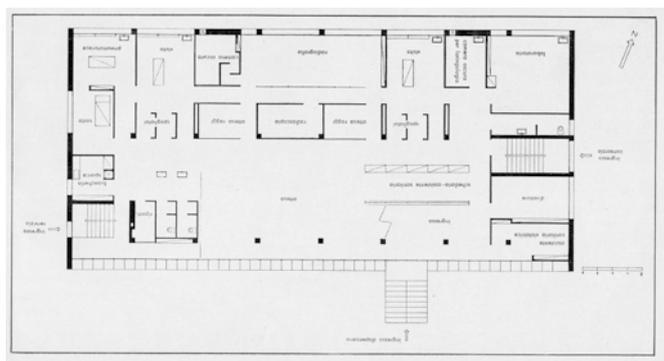


Fig. 84

Ignazio Gardella, Anti-tuberculosis dispensary of Alessandria, 1934.

Fig. 85

Josep Lluís Sert, Anti-tuberculosis dispensary in Barcelona, 1934-37.

Fig. 86

Top left Enrico Del Debbio, Heliotherapy colony at the Foro Mussolini, Rome, 1933-35. BBPR, Heliotherapy colony of Legnano, 1937-38.

sandria, Sert-Torres, Barcelona), heliotherapy colonies (BBPR, Legnano, Del Debbio, Rome), marine colonies (Mazzoni, Tirrenia, Busiri Vici, Cattolica, Vaccaro, Cesenatico, etc.) or sanatoriums (Duiker, Hilversum, Lurcart, Puy de Dome, Aalto, Paimo) in which modern architects can assert themselves in their primary role.

It is precisely in the characterization of these care spaces outside the hospital (in Italian cases also net of the rhetoric of the regime) that we find that well-balanced attention between functional device and architectural identity that can be taken as a starting point for the design of contemporary Community Houses.

In the case of the anti-tuberculosis dispensaries, on the one hand Gardella in Alessandria (1936-38) and on the other the rationalists of GATEPAC, Sert, Torres Clavé and Subirana in Barcelona (1934-36) implemented the same envelope with modulated transparencies (thanks also to the use of glass blocks in both buildings) within different planimetric systems; linear in the case of Alexandria, L-shaped in the case of Barcelona. It is precisely in Barcelona where, in addition to the spaces for prophylaxis and preventive analysis of tuberculosis diseases, there is a library and an auditorium, perhaps in an attempt to enrich the strictly sanitary equipment with cultural and social functions useful to the population.

The heliotherapy colonies had a strong impulse in the Fascist era to combat childhood rickets and in general to encourage the strengthening of young

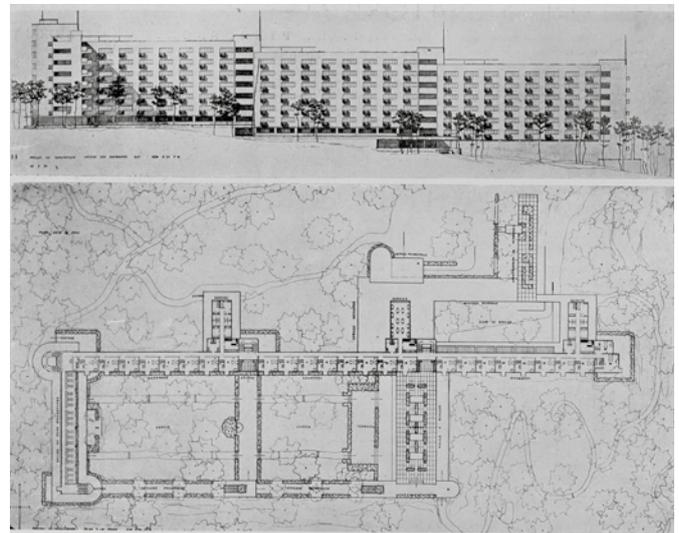
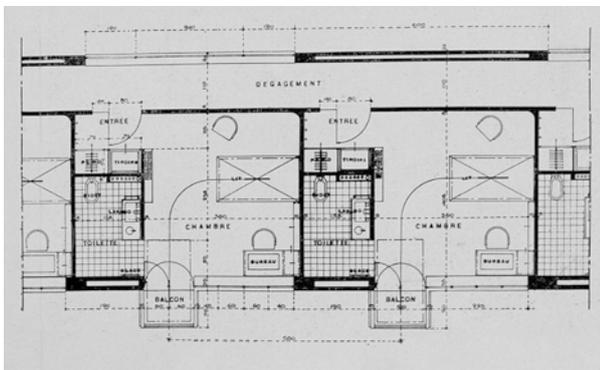
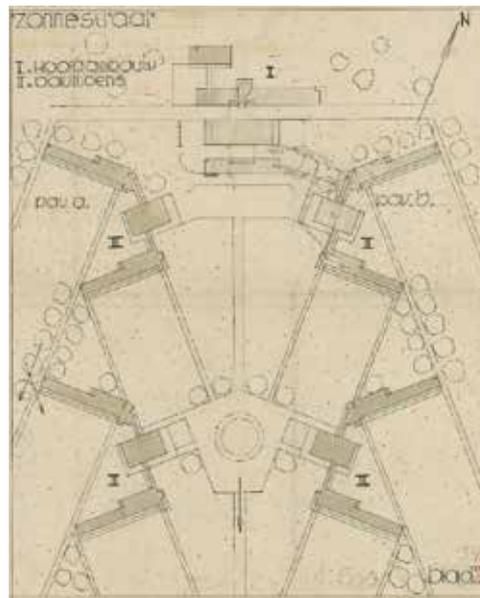


Fig. 87-88

Jan Duiker, Zonnestraal Sanatorium in Hilversum, 1920-28.

Fig. 89-91

André Lurçat, Puy de Dome Sanatorium in Durtol, 1929.

people from the lower classes through exposure to the sun. They are often placed on the outskirts of cities in the healthiest positions and organisms that seek the best sun exposure in the conformation of the system. If the BBPR in Legnano (1937-38) adopted a composite layout divided into two formally geometric parts, the large hall on one side and the ancillary rooms on the other with the stairwell acting as a pivot, Enrico Del Debbio in Rome (1933-35) made the adaptation to the place a compositional principle that, starting from the head, first developed in a linear manner and then curved around a circular garden. Less constrained to the environment are the marine colonies, which were nothing more than heliotherapy colonies placed near the sea in order to enjoy thalassotherapy to the fullest.

Sanatoriums were also substantially based on the principle of heliotherapy and were structures created to counteract long-term chronic diseases, typically respiratory diseases such as tuberculosis.

Among the out-of-hospital care spaces, this is the case in which the structure is closest to the traditional hospital in terms of size characteristics. Nevertheless, there is no adoption of hospital typological models, but the invention of types that, in addition to conforming to the landscape, become total institutions and “collective housing models”. Architectures perfected as “typological devices to capture the sun” through terraces or verandas as an extension of the living rooms or, in ideal cases, as real outdoor rooms. Finally, sanatoriums allow us to recover a significant European experien-

ce conducted by architects of the Modern Movement. We imagined these spaces through the most famous sanatorium in literature, the Berghotel Schatzalp in Davos, designed by Otto Pflughard and Max Haefeli of Zurich in 1899 and beautifully described by Thomas Mann in *The Magic Mountain*. Unlike the latter, which is very advanced from the point of view of therapeutic spatial conformation but still rather vernacular in its architectural language, the examples we cite also accompany a specific typological reflection in adopting, for example, the principle of steps in section, as Tony Garnier did in the project for a heliotherapy establishment (1917) designed as part of the sanitary sector of the Cité Industrielle. ,

As far as the realizations are concerned, however, the Zonnestraal sanatorium in Hilversum by Jan Duiker (1920-28), is the first reference built by reinventing the typology of the pavilion through a logic of free articulation in the space often characterized by valuable natural wooded landscapes. The individual parts, therefore, are simultaneously subject to both the general principle of the layout and the principle of asymmetries of modern architecture.

Coeval with Duiker's sanatorium is André Lurçat's Puy de Dome sanatorium in Durtol (1929), a planimetrically linear building that takes advantage of the slope of the land to divide the 6-storey height into 3 portions. The attention to the patient's home is maximum, including the functional need for direct exposure to the sun, solved by rotating the bed directly on the outdoor balcony.

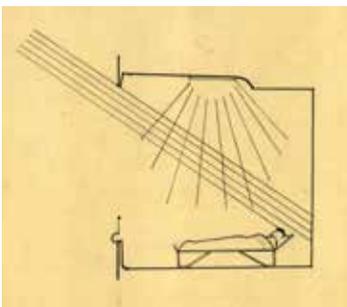
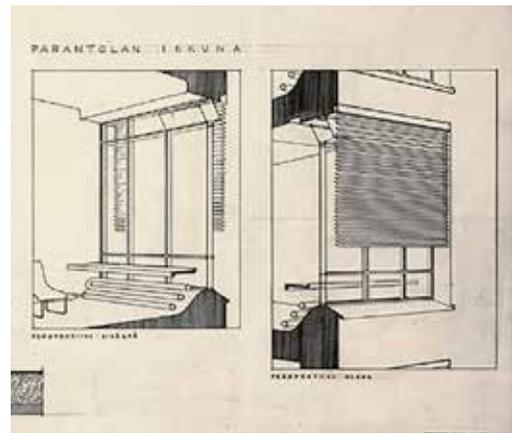
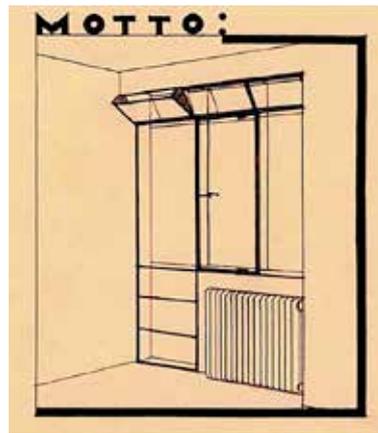
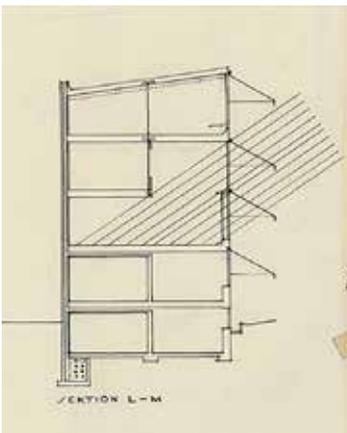
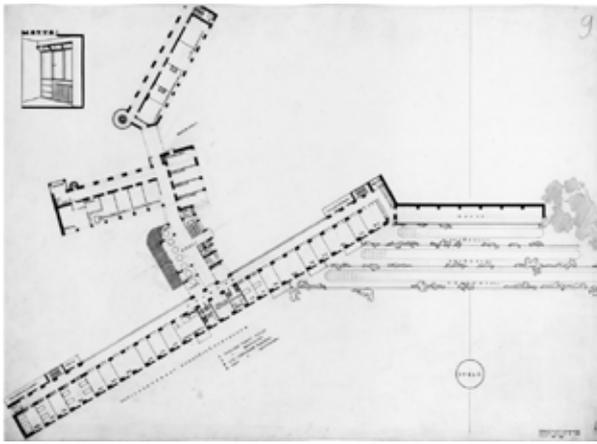
But it is above all Alvar Aalto, who had the opportunity to visit both the Duiker and Aalto sanatoriums on a trip in 1928, with the Paimio Sanatorium (1929-33) who succeeds in making sanatorium architecture a syncretic example of functional and aesthetic quality.

Aalto himself writes that "The primary purpose of the building is to function as a medical instrument... One of the basic requirements for healing is to offer complete peace" (Pallasmaa 1998, 17). We discover a vocation of Aalto himself in the design of sanitary spaces since before Paimio he had built the small municipal hospital of Alajärvi (1924-28), two homes for the elderly and participated in the competitions for the spa in Pärnu, Estonia and for the sanatorium in Kälviä. In 1931, he also participated in the competition for the central hospital in Zagreb, but did not rank. "The unique quality of the project lies in the combination of strictly functional and technical criteria with shrewd psychological considerations" (Pallasmaa 1998, 17).

The latter were probably also due to the concrete identification of the needs of the patient that Aalto had been able to make since the personal experience of a hospitalization while he was designing the sanatorium had led him to accentuate the patient's point of view with respect to the hospital environment, that is, it had allowed him to put himself in the condition of maximum weakness.

Mostly known as an architectural masterpiece that occupies a precise place both in the history of European architecture and in the works of the Finnish master, the Paimio sanatorium fully expresses the conception of humanized architecture. Unlike the same current that spread in the design of health care buildings in the second half of the twentieth century – the humanization of the hospital – in which the need is detected as a medical necessity, the humanization of Aalto's architecture starts from the architect as necessary attention to the psychophysical needs of man (Aalto 1940).

It is precisely in an article published in the MIT magazine in 1940 that Aalto gives as an example the design attention paid to the patient that he himself adopted in Paimio.



Figg. 92-97

Alvar Aalto, Paimio Sanatorium, 1929-33. Plan, view and details

The latest typological evolution of the place of care in its hospital form is characterized by a horizontal rather than vertical development in defining a structure commonly called “plate”. Thanks to the imposition of the mega-structural movement of the Sixties, which affected all the main public urban functions, the hospital also adapted to this trend, becoming a complex mechanism for the concentration of differentiated spaces and places (wards, hospitalizations, diagnostic services, operating blocks and university clinics). In this way, different spaces and functions are integrated, so that in its complexity the hospital itself becomes a metaphor for the city and also introjects its distributive and spatial taxonomy, for example in defining internal streets, paths or squares, large central reception spaces. Among these complexes is the Mc Master Health Center in Hamilton, Canada by Eberhard H. Zeidler (1965-71), a large, almost square modular plate from which emerge the transparent towers that contain the ski lifts. The planimetric density creates an intercalation between served and serving spaces within which the voids necessary to give air and light to the interiors alternate. The modular order of the upper floors contrasts with the more disorderly ground floor in the insertion of exceptional functions and spaces such as the large conference room. In Italy, there are more project proposals than actual constructions of hospitals based on this typological model. The competition for the new hospital in Venice in 1963 in its most interesting invention consisting of the “Tadzio” project by the group Romano Chirivi, Costantino Dardi, Emilio Mattioni, Valeriano Pastor and Luciano Semerani provided inspiration to Le Corbusier for the famous turbine plant later developed into a single-storey organism in the project that the Swiss master presented in 1965. Both the Mc Master Health Center and Le Corbusier’s Hospital can be ascribed to the examples of plate compositions, also known as Mat-Building, according to the formulation of Alison Smithson and Shadrach Woods, evidenced by their project for the Frei Universität in Berlin in 1963.

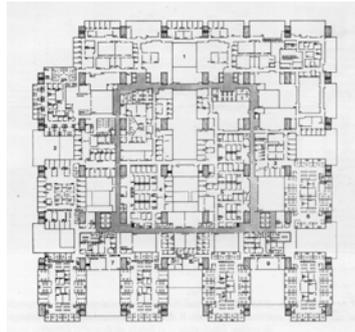
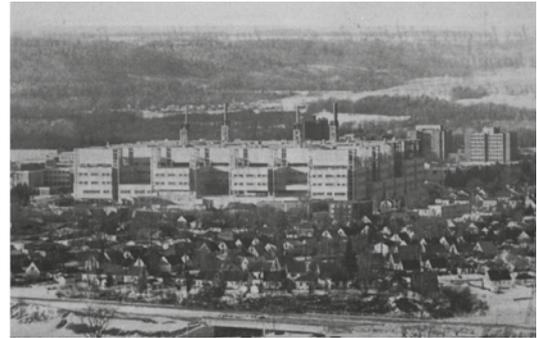
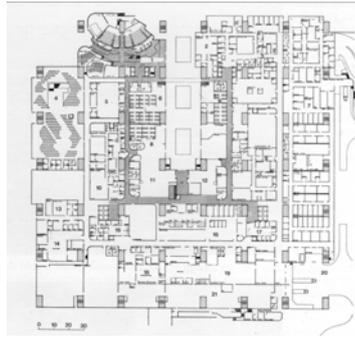


Fig. 98-102

Craig, Zeidler & Strong, Mc Master Health Science Center, 1965-71. Photograph of the model, plans and views.

A variant of the slab hospital is the slab-tower hospital in which, starting from the one- or two-storey slab base, some functions are concentrated in a block developed in height, “tower-shaped”. This is the case of many structures that we still use today, which have grown over time due to progressive additions that are not part of an organic design.

The demographic contraction, the territorial dispersion and an endemic lack of financial resources to invest in healthcare construction have meant that in Italy the issue of care spaces and more generally of hospitals has essentially taken a back seat, at most the subject of autonomous specialist additions or isolated integrations. The last thirty years of the Short Century dominated the last thirty years of the short century, such as the two hospitals built by Luciano Semerani, in Trieste Cattinara (1969-71) and Venice (1979-83), and Carlo Aymonino’s project for the New Hospital in Mestre (1988), later completed by Emilio Ambasz.

To bring attention back to the theme of the Hospital, Renzo Piano has also thought of it who, at the head of a working group identified together with the then Minister of Health, Umberto Veronesi, creates a new model of Hospital that will be included in the National Health Plan 2001-2003 based on a decalogue of intent consisting of as many keywords such as Humanization: Urbanity: Sociality: Organization: Interactivity: Appropriateness: Reliability: Innovation: Research: Training.

Despite the fact that the commission hoped for the construction of 40-50 hospitals throughout Italy (which would have completely refounded the system of care spaces), there are few hospitals that adopt these premises. A meta-project remains of that prototype that also involves the typological aspects:

It is a new TYPOLOGY OF HOSPITAL, WHICH WE WANT TO DEFINE multi-block, WHICH WOULD LIKE TO CAPTURE THE GOOD OF THE TYPOLOGY WITH PAVILIONS (= HUMAN SIZE) AND MONOBLOC (= GOOD FUNCTIONALITY OF THE MACHINE, GOOD PATHS BUT ALIENATION).

THE NEW TYPOLOGY IS DESIGNED TO BE ABLE TO EFFECTIVELY COMBINE PLEASANTNESS AND FUNCTIONALITY (Mauri 2001).

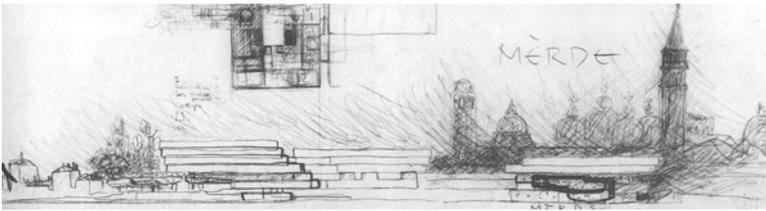


Fig. 103-104

Romano Chirivi, Costantino Dardi, Emilio Mattioni, Valeriano Pastor and Luciano Semerani, "Tadzio" project in the competition for the new hospital in Venice, 1963. Section and perspective.

Fig. 105-106

Le Corbusier, Project for the hospital of Venice, 1965. Photograph of the project presentation and floor plan.

Coming to the present day, we can consider this brief but truthful (as Longhi wrote about his history of Italian art) a history of the type of welfare-hospital and its relationship with the city to be concluded.

However, not before mentioning a last experience, in some ways paradigmatic, which concerns the international competition for the new hospital in Cremona alongside the previous one. Recent news has been the choice of the winning project from the shortlist of the five finalists selected for the second phase: MCA - Mario Cucinella (Bologna), Park Associati (Milan), Foster + Partners (London, Great Britain), Baumschlager Eberle Architekten GMBH (Lustenau, Austria), O.M.A. Office for Metropolitan Architecture (Rotterdam, Netherlands). We are not given to see the projects not yet published except that of the winner, Mario Cucinella, a large circular ring that in the best contemporary Italian tradition shows off a landscape semblance stuffed with a sustainable technological apparatus but which forgets the great typological-compositional lesson.

Renzo Piano's pupil would have been expected to adhere more closely not so much to the general principles of the meta-project, but to that typological suggestion defined as "multiblock, which would like to grasp the good of the pavilion (= human size) and monobloc (= good functionality of the machine) typology that Piano himself indicated in the document and which he translated into some of his prototypes.

From the first press releases relating to the competition, old and new slogans such as "city within the city", "garden covers" and "climate forests" leak out. A "non-architecture" hidden in an artificial green landscape that colludes with the nearby "great river", the Po, and its precise geometries: provided, as so many recent cases teach us, the features are not a specious exaggeration of the renderer on duty. Here, however, it is imperative to suspend the judgment pending more detailed material.

In consideration of the purpose of this article – not an in-depth historical research on the type of hospital but a contribution of critical-cognitive support to the design – the search for a prototype of a Casa della Salute/Casa di Comunità, i.e. a new architectural type, is an operation to be carried out on the basis of the interpretation of the historical experience of the care spaces, while analyzing the needs and potential in terms of urban devices.

Notes

¹ The Commission of the Ministry of Health, chaired by the Minister prof. Umberto Veronesi, coordinated by the architect Renzo Piano, for the study and development of a new hospital model with high technological and healthcare content. Piano-Veronesi project model, 2000 was made up of 16 members: Raffaella Bucci, Giuseppe Caggiano, Antonio Cicchetti, Vittorio De Martino, Paola Di Martino, Velia Gini, Claudio Giuricin, Maurizio Mauri, Marcello Mauro, Laura Pellegrini, Michele Pinus, Manlio Tesio, Alessandra Vittorini.

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Giorgio Milanesi
Caring Architecture in the Middle Ages: Models and Anti-models for the Contemporary?

Abstract

The theme of care structures has always accompanied the development of Western society. The advent of Christianity attempted to systematize the dynamics of reception by proposing solutions on an urban and extra-urban scale which inevitably changed over the centuries as the settlements changed and the cities themselves changed. A reflection on contemporary healthcare architecture must, however, take into account the variations that occurred between the Middle Ages and the modern age to critically question the different solutions that have gradually been proposed in individual contexts.

Keywords

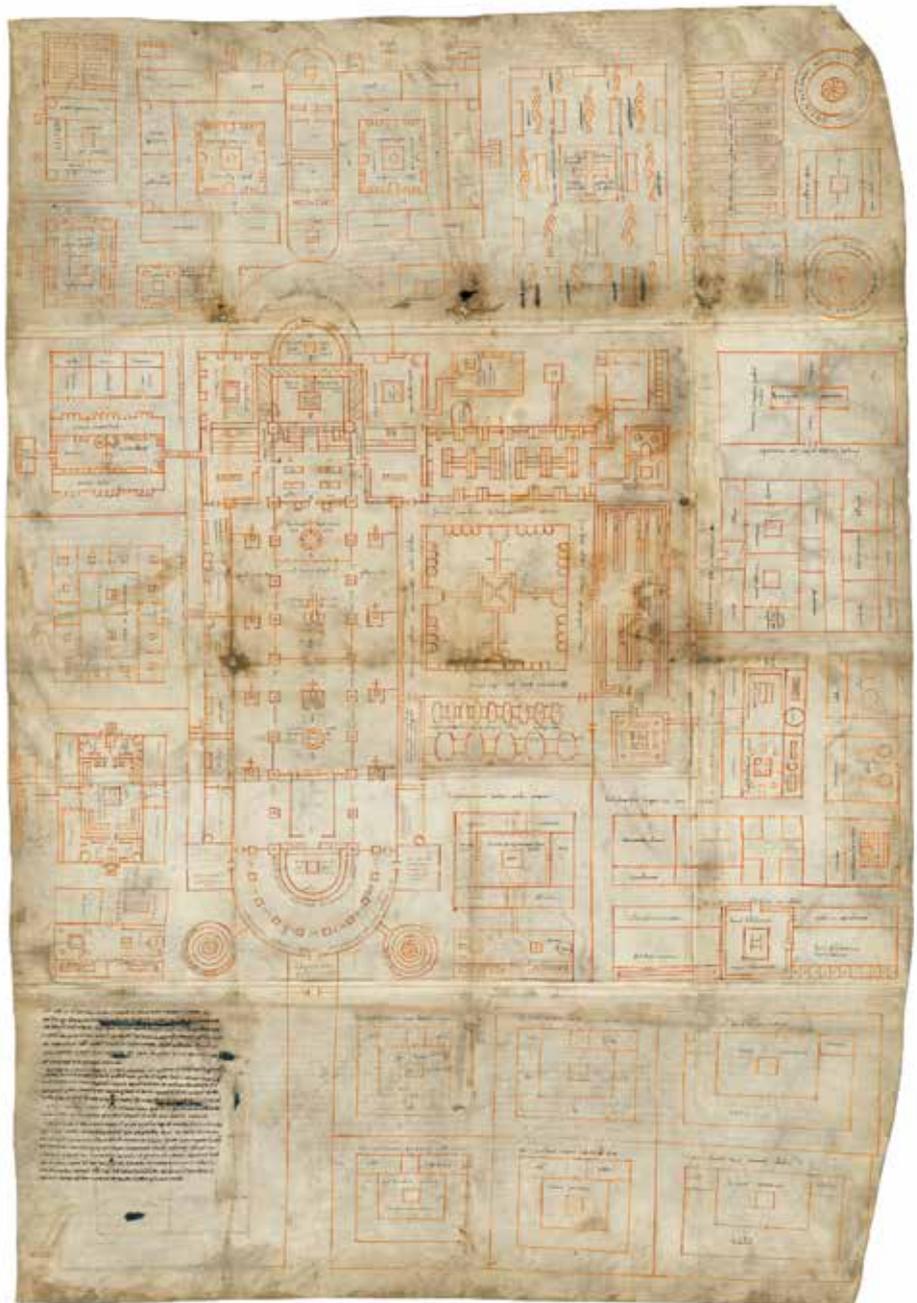
Xenodochia — Hospice — Hospital — Medieval hospitality — Monasteries — Pilgrims

When we consider the genesis of organized welfare structures we have necessarily to start with the hospital founded by Basil, future holy bishop of the city of Caesarea, now Kayseri in Cappadocia, Turkey. Built extra moenia with an adjoining church and monastery, it came into being around 370 in close relation to the Basilian monastic conception, which flowed into a rule that predated the Benedictine one by about two centuries; this rule was aimed at the spiritual and physical care of the person as one of the most edifying Christian acts. The idea of creating places intended for care cannot be separated from the idea of the good Christian who must care for the soul and at the same time for its container, according to that doctrinaire reference to *Christus medicus* that, from a hagiographic point of view, will find fulfillment in the “medical saints” Cosmas and Damian. In pre-Christian antiquity there were, of course, places for the care of the needy, but it was mostly run by families with rare cases of partial communal management of slaves or wounded soldiers returning from endless military campaigns.

What jumps out at us regarding the first organized experiences that we label for convenience “charitable” in the centuries of late antiquity and throughout the early Middle Ages is the, we would say today, polyvalent character of the services offered. The earliest *xenodochia*, whose etymology, not surprisingly, refers simply to a kind of “refuge for strangers,” in the evidently all-Christian sense of unselfish welcoming to all, offered help to various types of “needy” people: certainly the sick, but also the poor, those with ambulation problems, the elderly, orphans, beggars and, of course, with great fortune in later centuries, pilgrims. It is necessary, however, to wait until the end of the 8th century, with Alcuin bishop of York, to be certain of the substantial coincidence between *xenodochia*, hospices and

Fig. 1

Plan of the Abbey of St. Gallen,
9th century, Cod. Sang. 1092.



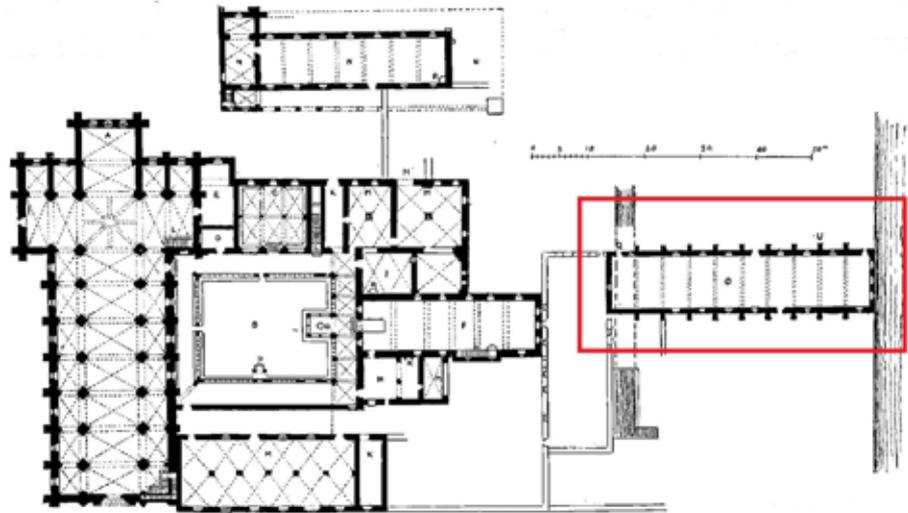
hospitals, suggesting a linguistic division that was not easily found in the factual context. For these centuries, and basically until the High Middle Ages, we are not able to identify architectural specificities, except by resorting to purely monastic models, with the caution, however, that the planimetric typology of the monastery consisting of a church, cloister on one side and adjoining spaces around it is a model that is substantially established in the late Carolingian period, leaving a textual and archaeological gap that is difficult to recompose for the previous half millennium. Since Pre-Carolingian monasteries were admittedly fenced-off places, tending to be isolated, although mostly visible, away from or on the periphery of towns, in which monks lived in separate spaces with the exception of the church, we must imagine that the structures that housed monks were the same as those that housed the needy. This at least seems to be suggested by the celebrated plan of St. Gallen (Fig. 1), from the first quarter of the ninth century, a plan that is more ideal than real, but nonetheless useful for reasoning about the spaces of a Carolingian monastic complex and thus of all Europe ruled by Charlemagne. The infirmary, houses for traveling monks, important guests, pilgrims and the poor are shown, as well as the bathhouse,

**Fig. 2**

Fossanova, infermeria dei conversi (Photo by G. Villa, from E. Gullotta, *La "costruzione" di un modello: l'impiego degli archi-diaframma nell'edilizia civile ducentesca del Basso Lazio*, Studi e ricerche di storia dell'architettura. Rivista dell'Associazione Italiana Storici dell'Architettura, II, n. 3; DOI: [10.17401/STUDIERI-CERCHE-3/2018-GALLOTTA](https://doi.org/10.17401/STUDIERI-CERCHE-3/2018-GALLOTTA)).

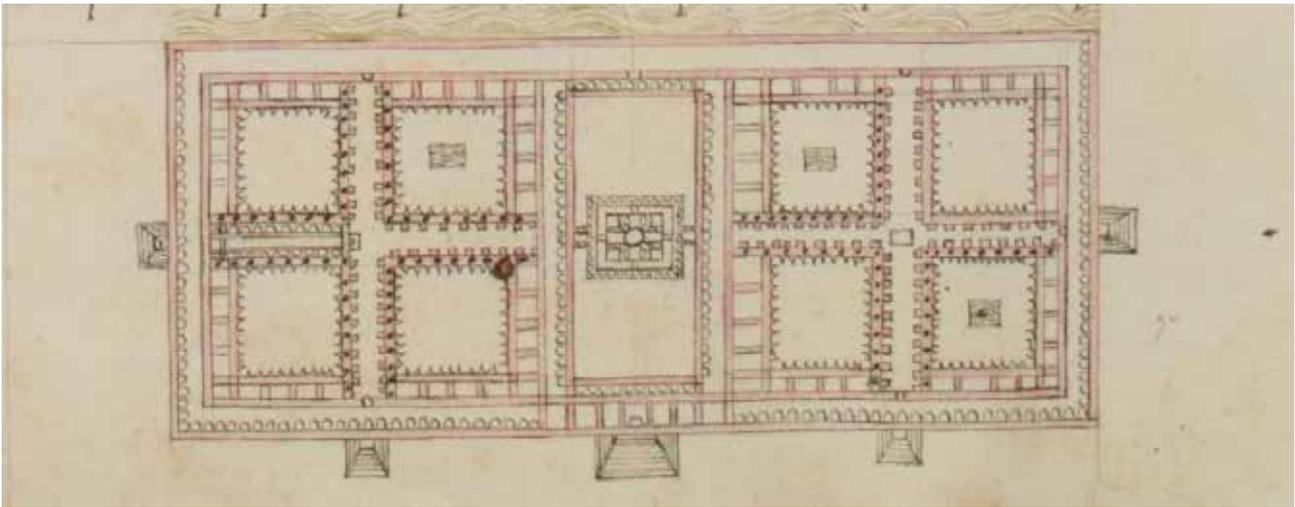
Fig. 3

Plan of the Fossanova Abbey, early 13th century (from C. Enlart, *Origines françaises de l'architecture gothique en Italie*, Paris 1894, p. 26); in evidence, the lay brothers' infirmary, detached from the spaces reserved for the monks, adjacent to the water.



se, kitchen, medicinal plants, doctors' quarters even the salassium room. In the literature, the two fundamental step changes are that identified between the the end of twelfth and the thirteenth century and that of the fifteenth century, actually as a long wave of the Black Death of the mid-fourteenth century. In the first case there is an exponential increase in foundations for assistance in Europe, an increase dictated by new general conditions (the so-called Revival of the 12th century), conjunctural ones (the increase in the number of pilgrims with the Crusades), and political ones, in reference to a greater number of actors at play. No longer are there only the Benedictines, their Cluniac "spin-off", and the bishops to carry the burden, but now we can also encounter new orders such as the Cistercians, the Premonstratensians, monastic-chivalric orders such as, precisely, the Hospitallers of St. John, and finally, in the decades at the turn of the 1200s, the Humiliati and then the beghine movement, and immediately afterwards the mendicant conventual orders, Franciscans and Dominicans. Among the actors in play, in the 12th century the laity also entered powerfully, both in the communal and proto-state forms of the great European powers, but also in new forms of Christian evergetism by which the setting up of a welfare structure no longer had anything to do with the Christian spirit and became mostly only a public manifestation of power, resulting in the rise of a new secular sanctity between the late 12th and 13th centuries, a phenomenon on which André Vauchez has written seminal pages. However, the 12th century is also unanimously considered the temporal range of the rediscovery of the centrality of the city. The effects are immediate: cities become wealthier, the greater the attraction of population, hence greater problems of care management, consequence: exponential increase in the number of hospital facilities. It is no coincidence that the Salerno Medical School reached the height of prestige in the 12th century, and by the first decades of the 13th century physicians wanted by the municipality appeared for "collective" care.

However, this does not mean that hospital facilities became "medical clinics." The earliest Benedictine survivals in relation to infirmaries or spaces for care in general date from the 12th/13th centuries, but it is evident, as in the case of Canterbury, Ourscamps or in Fossanova itself (Figs. 2-3), the dependence on church and monastic planivolumetric models in general. It is precisely in these phases, however, with the renewed and intense involvement of the laity, that the typology of the hall hospital begins to gain strength, which Fabio Gabbrielli (2020) specifies has nothing to do with the various *Hallenkirchen* models and rather we need to think of quadrangular spaces, whether or not divided into two or three naves, covered va-

**Fig. 4**

Filarete, Plan of the Ca' Granda (Ospedale Maggiore) of Milan, from *Trattato di Architettura*, 1464 ca. (<https://archive.org/details/mss.-ii.-i.-140-images/page/n183/mode/2up>).

Fig. 5

Milano, Ca' Granda (Ospedale Maggiore), today, home to the University of Milan.

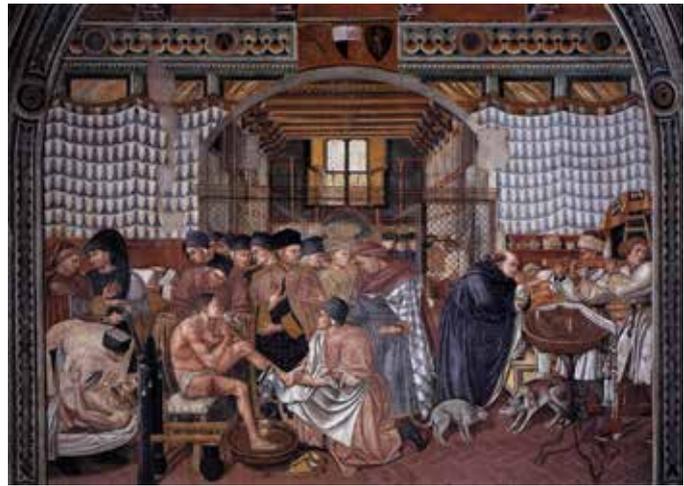


riously with exposed trusses or vaults, and very longitudinally developed with the only addition of a chapel inserted in the perimeter itself or in the immediate vicinity.

It's now accepted fact that there is a connection between the great health crisis caused by the plague epidemic of about the middle of the fourteenth century and the great second change of pace, that of the late fourteenth/early fifteenth century, with the emergence of new mammoth structures (hence the various "Ospedale Grande" or "Maggiore") that saw the fixed presence of physicians (or apothecaries), gradually abandoning the multipurpose as well as polycentric character of care facilities that had characterized the reception system in the previous thousand years. This is counterbalanced, as is well known, by a different architectural model, the so-called cross-shaped layout (Fig. 4), a layout on which many scholars have focused in recent decades in order to understand primarily its origin—from Pavia, from Milan (Fig. 5), from Brescia, from Florence...—and, above all, its design intention. In general, the plague had taught that the dispersion of care spaces had not optimized the response to the pandemic. Having myriad locations scattered throughout the territory had proven ineffective, no matter how strategically located or along obligatory thoroughfares. The response was therefore a concentration of welfare facilities, now less multifunctional, certainly more specialized, and tending to be linked to a secular power no longer the almost exclusive preserve of the Church or religious orders (Figs. 6-7). However, it is clear today that the "Great Hospitals" model had not been applied uncritically; on the contrary, where it was understood that the specific conditions of a city or territory led to the strengthening of the old model of widespread welfare architecture there was a tendency to

**Fig. 6**

Florence, Biblioteca Medicea Laurenziana, Ms. Gaddiano 247, early 14th century (<http://www.culturaitalia.it/viewItem.jsp?language=it&case=&id=oai%3A-scalarchives.com%3A0009678>).

**Fig. 7**

Siena, Ospedale di Santa Maria della Scala, Domenico di Bartolo, *Cura dei malati*, 1440-1441 (web source)

optimize the coexistence of new and old systems.

Tapping into architectural history as a catalog of solutions on which to set new design systems, as is well known and, I might add, obvious, is a very delicate operation. It becomes an almost foolish operation to assume for other contexts the “geometry” of an architectural complex designed for a specific space and time, with as many specific needs and purposes: the risk of the “Las Vegas effect” is just around the corner. These obvious considerations become perhaps more pregnant if we think of architectures dedicated to care in a broader sense; I find it more intriguing, if anything, to question the reasons for the choices that from time to time determined individual projects, to investigate the religious and “political” actors at play, to study spatial innovations under equal environmental conditions, to collate different projects. A PRIN entitled *At the Origins of Welfare (13th-16th Centuries). Medieval and modern roots of the European culture of assistance and forms of social protection and solidarity credit*, was dedicated in 2015 as general reflection, including architectural reflection, on these issues. Well, although studies on the medieval and early-modern welfare system were not lacking for the Middle Ages as much from a historical point of view as from an architectural history point of view, a general (and global) reconsideration of the issue has contributed in the very last few years to the publication in Italy and elsewhere of miscellaneous volumes that, if on the one hand, offer broad reconstructive scenarios of the origin of welfare systems (Bianchi 2020, also for its impressive bibliographical apparatus, has become a reference text to be complemented by the very recent Barceló Prats 2023), on the other hand, through specific case-studies (e.g., Siena, on which Gabbrielli 2023 most recently reports), a perhaps too ideological conception of the problem of medieval and modern care practices has been partly reshaped in favor of a more specific analysis of contexts. And one of the outcomes that such specific research has strongly suggested is that at some point at the end of the Middle Ages, there emerged enterprises, we would say today, *mutatis mutandis*, “private state-sharing” designed for public welfare (Figs. 8-9). These were structures certainly connected to ideals of propaganda and self-promotion of the ruling classes, but at the same time, without going so far as to arrive at an overly idealized image of welfare between the medieval and modern ages, connected to the revolutionary idea for those times that the greater the number of people in a given territory who could have decent standards of care, the greater the wealth and general welfare.

This aspect certainly deserves all the attention because it projects the care issue, already in the Middle Ages, in a dimension that goes beyond the architectural, anthropological, social or banally health issue. The discussion

**Fig. 8**

Paris, Musée de l'AP-HP, Jehan Henry, Livre de vie active de l'Hôtel-Dieu de Paris, ms. n. 59, fol. 77, Cura dei malati, 1482 (<https://www.calameo.com/read/0040218272001b4dbfc02>).

**Fig. 9**

Parigi, Hôtel-Dieu, wood engraving, circa 1500 (<https://iiif.wellcomecollection.org/image/V0014307/full/full/0/default.jpg>).

of possible medieval and modern models or antimodels, in order to have useful repercussions on the most recent design solutions tending toward integrated systems of care starting from an urban scale, should focus on the problem not so much and not only of efficiency, which is certainly an inescapable aspect, but also on the question of the real impact on the daily well-being of a community. It seems to me that this is the real bottom line: no architectural model in almost two thousand years has solved the issue, but multiple models adapted to individual territorial contexts has led to increasingly satisfactory outcomes. While it is clear that Community Health Places and Centers recall, at least on paper, the earliest late medieval and early medieval multifunctional hospitals, they depart from them in their polycentric character, based on spatial distribution in a given territory, which could invariably have been lowland, sea, road, coastal or river town or valley territory. In contrast, the “spatial thickening” of the late medieval and modern *Ospedali Grandi*, the model of which is sometimes still applied, concentrated care on the urban level, but the extreme medical specialization caused all other equally necessary services to the person to be lost sight of, diluting them into rivulets with little or poor communication between them.

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

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.

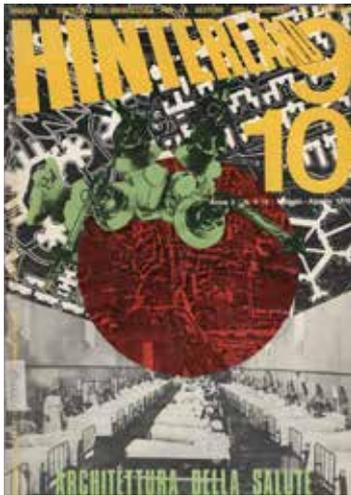
Keywords

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

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

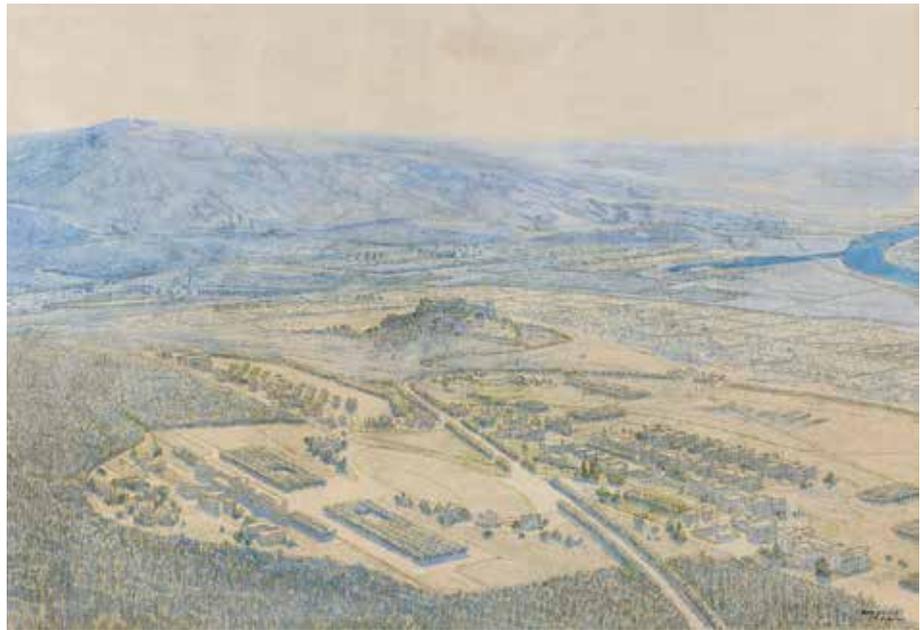
Cover and internal pages of the magazine *Hinterland*, 9-10, may-august 1979, titled *Architettura della salute*.

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 overview¹, 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

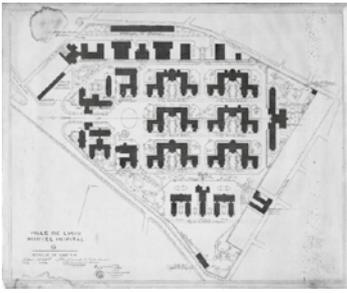
the socio-settlement features of the user population.

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-

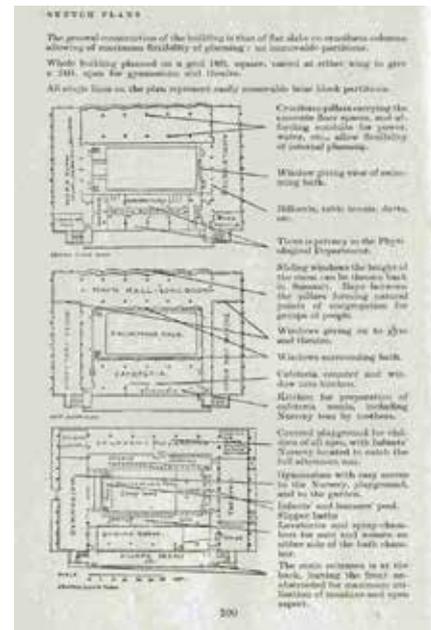
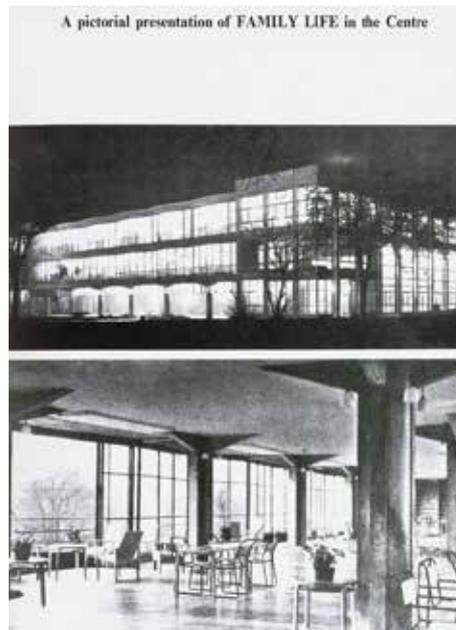


Fig. 9-11
Sir Owen Williams, Pioneer Health Center, Peckham, 1935.

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

¹ 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).

Carlo Quintelli
**From Community Houses to Community Health Places
 and Centres: an evolving model**

Abstract

The theme of the Community House, as an evolution of that of Health, involves the extension of the functions but also of the representativeness and civil role of this new public service structure, thus prefiguring further prospects for identity development. However, the advancement of organizational and management planning, in the performance interrelation that marks the dimension of care in a social as well as medical sense, does not correspond to an equally developed design paradigm dedicated to physical, architectural spaces, capable of characterizing and providing a specific formal expression in terms of urban location, layout and figuration of these structures of socio-health decentralization. A contribution, that of the architectural project, which is also fundamental in contributing to making this new policy of healthcare decentralization supported by the programming of the PNRR communal, participatory and inclusive, i.e. urban.

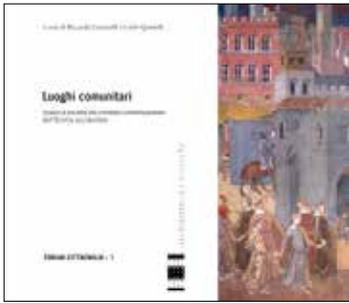
Keywords

Health House — Community House — Architectural project for healthcare — City and health



If we wanted to consider the Health Houses, now Community Houses, among the «new dominant themes» of the contemporary city – paraphrasing the epochal scansion of architectural typologies in urban construction according to the art historian Hans Sedlmayr at the beginning of the 20th century (1967) – we certainly could not find a significant case study of structures designed and built, remaining in the Italian context, nor a theoretical or applied research that could offer us a first framework of reference useful for the design of these new public works.

This consideration takes on particular importance in the face of a political planning dynamic, that of the PNRR, a direct emanation of the Next Generation EU, capable of investing huge resources in the creation of new centers intended for the need for decentralized health services, in a broad sense and in direct correspondence with the urban and territorial settlement.¹ It therefore seems appropriate to ask: when in recent history have so many resources been made available to create public service buildings in such a short period of time and in a systemic manner at a national level? We should go back to phases of strong expression of State planning in the field of public works, such as in post-unification urban construction or in the twenty years of fascism, net of first statist and then dictatorial rhetoric, up to a post-war reconstruction of long inertia between the 1950s and '60s, in that case rich in international reference models towards which Italian architecture looked with critical capacity and through a process of original and anti-rhetorical contextual declination where the city is taken as the primary interlocutor (Canella 1982). Emblematic in this sense is Olivetti's project of valorising the community meaning at the level of work but also educational, cultural and last but not least health well-being, capable of permeating all components of urban life thus overcoming the boundary between public and private in the search for a ethics as well as a shared



social utility.²

In general, these are historical phases where, through different methods and outcomes, the desire to support the construction strategy of public architecture emerges through design culture tools that have characterized not only the building itself, from the point of view of the innovative relationship between form and function, but also, no less, of the contribution to the transformation of the urban structure, of its landscape, through the definition of new collective places to increase the social and civil value of the city.

If we then ask ourselves about the epistemic reasons for an architectural design capable of applying itself to the theme of health so strongly solicited by the recent pandemic experience, the starting point can only be that of Ministerial Decree 77 (2022), which not only gives specific contents to an implementation strategy for basic health facilities across the entire national territory, something almost unique in Italian history, but above all it characterizes and combines the function of health with the sense of community, once again in the historical dialectic between *Gemeinschaft* and *Gesellschaft*, between individual bonds and social contractuality (Cantarelli, Quintelli, Prandi 2009).

The definition of «Qualitative, structural, technological and quantitative standards relating to territorial assistance» of Ministerial Decree 77 therefore constitutes the further push towards a model which in the Casa della Salute was limited to purely medical provision while with the Casa della Comunità the provision performance expands and diversifies, significantly transforming the very identity of the structure.³ A decisive step forward, long prefigured but now well characterized, which involves the evolution of healthcare practices in terms of prevention, active medicine, operational coordination that multidisciplinary can determine around the figure of the complex patient, and last but not least the statistical forecast included within management planning. A medical dimension integrated with that of social assistance, consultants, different services which however compete with an idea of welfare where health refers in a general sense to the individual person and not just to the living body affected by pathology. The common denominator for all these components, to be brought to the maximum level of physiological expression, appears to be that of the community dimension, at the same time the cause and effect of a new concept of health rooted in the social body of the city, in the neighborhoods and between the houses.

Faced with this metamorphosis of the primary healthcare model - expression of a shared policy at a European level⁴ - in the absence of references, experiences, tools of urban architectural planning the need for which is evident in order to be able to deal with typological and settlement interpretations where the concepts of health and of community overlap with those of functional space, public place, environment and landscape of the city, the role of research in an architectural and urban sense emerges more than ever, complementary to those of a healthcare and welfare, management and, up to to date, only mainly construction. The one undertaken by a group of teachers, researchers, doctoral students from the University of Parma⁵ which starts from the only preliminary material available, promoted by the ministerial agency Agenas, entitled *Guideline document for the meta-project of the Community House* by researchers of the Polytechnic of Milan (Capolongo 2022). An effective technical framework with the aim of «supporting strategic management, technical offices and designers in the planning and design of new Community Houses, Community Hospitals and Territorial Operations Centres», where the main qualitative and quantitative data are clarified, the device mechanisms, the functional orga-



nization, the typical distribution matrix and other parameters for the functioning of the structures for which the typical recommendations of a logistical, technical-sanitary and technological-constructive approach prevail. The part of the document concerning the theme of architectural spaces, of the typo-morphological variables that can interpret a functional, but above all fruitful, complex device appears more generic and of relative capacity for direction, where the formal, figurative, iconic, chromatic and no less relational which significantly affect the responsibility of the project and consequently the overall quality of the architectural structure to be built.⁶

Nicoletta Setola's (2022) concise contribution on a role of architecture that must start from the urban dimension of the neighborhood and then unravel in the building's environments according to methods largely borrowed from *healthy buildings* and *evidence-based design* of the Anglo-Saxon school appears more detailed in certain respects. That is, from methodologies of a scientific nature, however substantially extraneous to a formal interpretation of the architectural space recalling a much more complex conjugation of factors, starting from those of a contextual nature.

It is not surprising that the architectural component that should be part of the apparatus of organizational, material and human instrumentation for care, is however not included among the thematic categories of the detailed comparative analysis of primary care in the various European countries carried out by our national health authorities.⁷ Paradoxically, this lack of attention instead sees very different testimonies in other fundamental sectors of the public service, in particular in the field of schools as evidenced by the extraordinary historical architectural case studies and the most advanced research since the first training, that of childhood so close to the dimension of care, where the experiential and educational function of the environments significantly involves the architectural responsibility within educational projects (Prandi 2018).

It is therefore now a question of focusing attention on the competing aspects that signify the community and civil value of an architecture called to distinguish a new generation of health services in a social sense and also of territorial decentralization. One that should borrow only in part from technical hospital experience to seek its own, relating to a medicine close to people in terms of services but also of cultural belonging, of effective sharing, with respect to which it is fundamental, among other things, a specific quality of the forms and relational logics of the spaces to be adopted, according to that contribution of competence which, evidently, belongs to architecture.

Even historical experience, capable of providing causal presuppositions and analogical support for research prefiguring the future, would seem to suggest attention not so much or only to the models of industrial modernity where the architecture of health has developed typological machines dedicated mainly to production efficiency of care, relating to bodies rather than people⁸, but also to a proto-health era, starting from the re-foundation process of the city at the end of the early medieval period.

In fact, in that historical context of the revival of exchange circuits between city and city, already typified on a European geography, we find structures indirectly suitable if not specialized in hosting the first organized forms of care and assistance which, as Guido Canella observed, express a «widespread articulation, directly and widely in contact with the established community» according to spatial logics capable of putting «the most varied humanity into contamination», thus verifying the «dialectical return in the body of architectural and urban planning facts» (1979) which the contemporaneity of social reasons and community of the topic still requires us to reconsider and evaluate thoroughly. These are *xenodochi*, predominantly



Fig. 3
Urban characterization for Community Health Places.
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free reception and assistance spaces for foreigners, pilgrims but also poor and fragile people, capable of restoring in a nutshell the sense of a virtuous conjugation between the actions of solidarity and those of care to which, *mutatis mutandis*, today we go back to look. A useful reflection in conceiving the lines of research of a design that wants to regain the social meaning of healthcare that we should hopefully attribute to a Community House. Starting from these assumptions, as well as from the now urgent need in the face of the PNRR programming, to fully involve the contribution of architecture in this important theme, a group from the University of Parma intended to carry out a research entitled: *From House of Health to that of Community, up to the Places and Centers of Community Health*: a strategy of direction for architectural and urban design, with the aim of providing some operational as well as conceptual tools projected into the continually evolving perspective on the role and identity of the Community Houses, underlining their socially productive meaning as well as belonging.

A research perspective where the two spheres of the interpretative problem that addresses the thematic conjugation between health and community, according to a semantic as well as phenomenological reciprocity, recall as many categories of the project, first and foremost of a scalar and typological as well as functional order.

One concerns the role that these new decentralized structures determine within the city or nuclei of the urbanized territory, conditioning the potential for urban significance in places of public space, in the morphological, functional structure and social representativeness.

The other focuses on the architectural organism as a spatial device capable of interpreting the complexity of the interrelationships between social and healthcare components to the maximum degree of synergy and valorization of the actors and foreseen situations.

Both categories are connected and are brought within a single analytical and proactive process: that of architectural and urban composition as the primary tool in the design of buildings and places in the city, in particular if of a public nature and of high social significance.

The urban dimension of the theme highlights, in dialectic with the typological entity of the building understood as a Center for public services, the need to conceive first of all a Place of Community Health, according to design criteria that serve to overcome the contingent and occasional logics

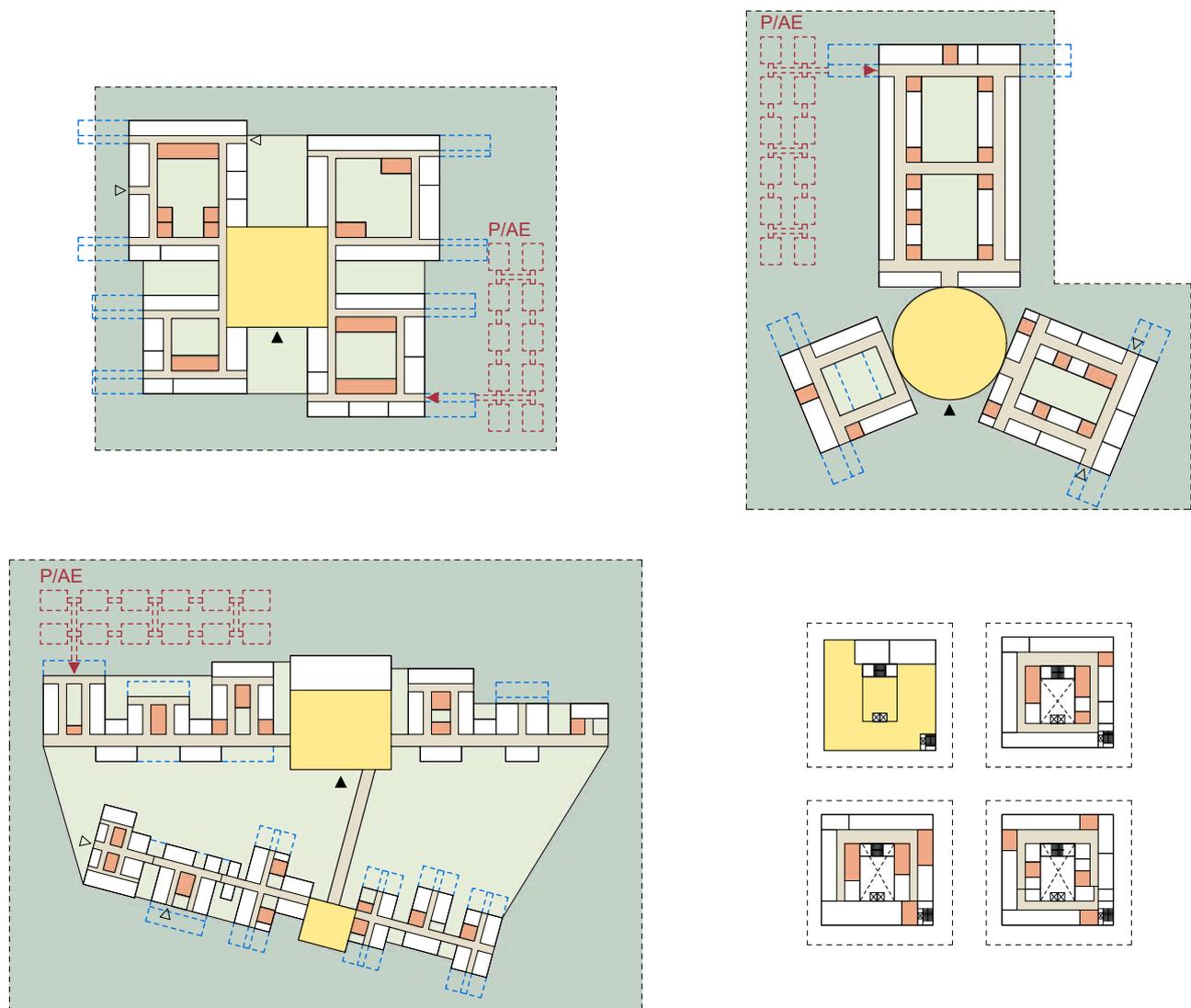
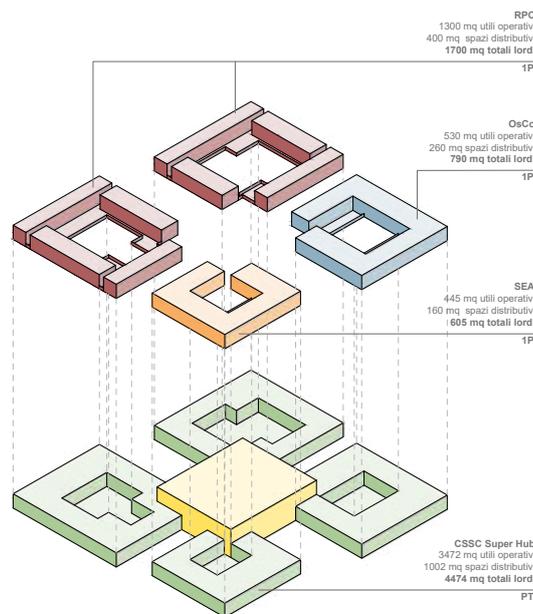


Fig. 4
 Typological studies for the superHub model:
 Specialized court typology
 Radial type
 Open aggregate type
 Multilevel typology
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through which abandoned and convertible areas or structures in the urban fabric are often identified when it is planned to build a Community House. Alternatively, at least as regards the Italian and European context of a city that still maintains a formal structure based mainly on the principles of morphological concentration and settlement polarization on the territory, a correct design approach would require a primarily positional strategy at the urban and neighborhood scale to cover the respective geographical settlement extensions, identifying the existing potential in terms of accessibility, in particular cycle-pedestrian accessibility and public transport, in relation to green and public spaces, seeking the maximum degree of complementarity with primary services, first and foremost public but also private such as the commercial one, frequented by citizens. Therefore contributing to the characterization of a place of integrated services, not only healthcare, aimed at citizens, for the different needs of the elderly and disabled, young people and women, families, in general for the quality of life within a neighborhood or an urban part capable of recognizing itself in a community form. Adopting in these terms an extended concept of health, aimed at both individual and collective well-being, where the factor of spatial quality, primarily urban as it is intrinsically social, cannot help but significantly impact the functioning of services but also on the sense of belonging, on the representativeness, on the processes of aggregation and inclusion of inhabitants who are at the same time actors and users on the scene of a place felt as their own.

Conformed spaces which, by virtue of these requirements, take on the va-

**Fig. 5**

Check for overlap between CSC, OSC and other functions.
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lue of real urban centralities in the different spatial typologies clearly perceived such as square, street-square, junction, urban campus, etc. etc. to be prepared within the neighborhoods as tools to arm with regenerative factors (Ugolini 2021) parts of the city often devoid of areas of life and social representation, increasingly replaced by shopping centers alone.

The characteristic of the architectural project understood in an urban sense, through the placement of health and social services in the built city, therefore constitutes a methodological a priori for the full achievement of the objectives already expected today regarding the Community Houses.

The typological dimension of the theme instead concerns architecture at the scale of the building, where it is not only a question of distributing but also of enhancing the characteristics and relationships between the health and social services provided according to a strictly complementary perspective. A spatial articulation capable of encouraging interprofessional exchange from which transdisciplinary practices characterizing a real socio-health community laboratory can arise (Quintelli 2023a).

Moving on the level of typological sizing, and taking as reference the categories of Community Houses indicated by Ministerial Decree 77 then taken up in the aforementioned Agenas-POLIMI document, the UNIPR research on Social-community Health Places and Centers aimed to add to the Hub model (indicatively dedicated to a catchment area of approximately 40,000 population-users) and the Spoke (for approximately 20,000 population-users), that of the SuperHub (for 70/100,000 population-users) as a further entity of extra-hospital territorial coverage particularly equipped with services specialized, for example regarding first aid and emergencies, both for health and social needs. A typological endowment whose scope of performance and service can therefore oscillate, in size and complexity, from the scale of the neighborhood to that of an entire urban sector.

Thinking in particular about the SuperHub, but not only, it seems logical to remove this type of structure from the domestic and individualistic identity to which the term “House” metaphorically alludes, also renouncing certain easily agreed-upon protective and consolatory suggestions, in favor of the name of Community Health Center. A Center that highlights the collective and participatory dimension of the citizen users, the performance caliber and the qualitative guarantee of the services offered, as well as the public representativeness of a space with high community value in the city in which one lives.

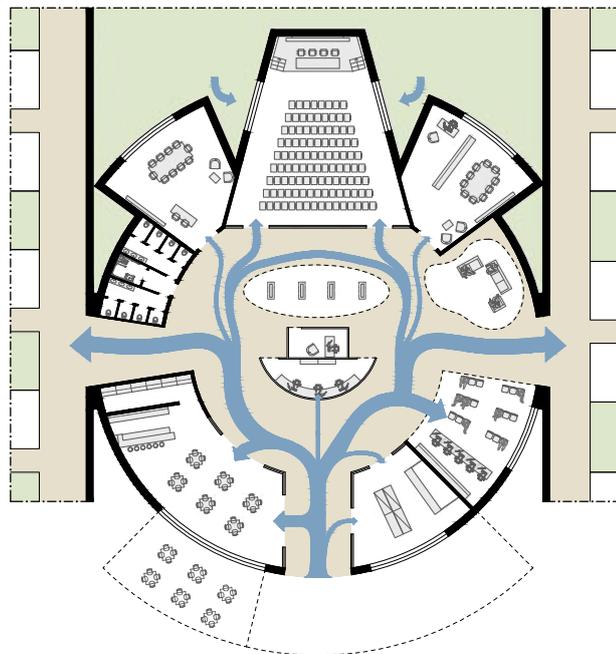


Fig. 6
Reception area for the SuperHub model.
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With respect to what we can define as the architectural scale of the project, the research focuses on the typo-morphological device, involving both the internal, closed, covered and open-air spaces, and the external, covered and open-air spaces of proximity. The formal and constructive potential of an innovative model of a new generation specialized building is verified and described in terms of distribution rationality, spatial sequences, access and connection logics, flexibility of use (not to be resolved with neutrality of shape), of the figurative characters between internal and external landscape through the different spatial components, of the identifying semantics, to which add the necessary design considerations in terms of construction, environmental and management sustainability for which reference is made to other already developed skills on the subject, obtainable from the general experience of constructing public buildings, starting with those for schools as well as hospitals. A process of a compositional nature that involves the dynamic perceptive dimension of the structure, where for example, with reference to the psychological analyzes of Ludwig Binswanger (2022), «the own space and the foreign space are not completely separated from each other, but they constantly merge into each other through the mediation of motor skills», therefore through the experience of a crossing that is not limited to reaching the desired destination but being able to grasp the sensations of a sequence capable of narration, of meanings and if we want emotions.

The approach of the research tends to codify compositional and generally design behaviors capable of returning an exemplary prototyping for the orientation use of a Community Health Centre, also highlighting the importance of those contextual factors and those cultural variables which, entering into dialectics with a given typological taxonomy, they will decline the parameters and principles with a view to a realism of the project to be sought from time to time, with respect to the different conditions of the places and operating conditions between new construction and building reuse. An architecture with a high degree of recognisability and iconic representation within the urban neighbourhood, a strong point in the strategy of the regeneration processes of parts of the city.

The typological conception investigated in the research work, through solutions primarily of relational as well as formal characterization of the spaces, also makes use of a case study comparison extended to an interna-



Fig. 7
Customized solutions for waiting areas
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Fig. 8
Pediatric area waiting sections.
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Fig. 2
Ignazio Gardella, Anti-tuberculosis dispensary of Alessandria, 1933-37.

tional scale where, without prejudice to the different healthcare systems, elements of interest that can be translated into the formalization of experimental models (Taheri 2024).

A similar framework of references has not found confirmation in Italy, where the few recent constructions have failed to define an original and characterized advancement of architecture intended for this important public function. We move between the realistic ambition of certain architecture aimed at spectacularizing and the trivialization of construction that limits itself to the fundamentals of minimum living comfort and functional standards (Quintelli 2023b; Simbari 2024). This does not mean that Italian architecture, even in recent times, has continued to deal with the theme of hospital healthcare, while the design experience of decentralized healthcare interventions of which the Ignazio Anti-tuberculosis Dispensary still constitutes an archetypal reference remains confined to the early twentieth century. Gardella in Alessandria, an architecture that we could consider prototypical with respect to the idea of House of Health.

The typological conception of a Community Health Center first of all addresses the issue of a clear design of the overall system, through relationships, sequences and logic of dispositive hierarchy of the formal components corresponding to the specificity of the environments used from both an operational and fruition point of view. Precisely, an idea of a unitary spatial device but corresponding to a complex and therefore necessarily articulated functionality, rich in potential as well as relational incompatibilities, to be brought to the maximum degree of organicity and physiological optimization starting from formal choices.

Here opens the chapter on the components of the device, i.e. the different environments functionally denoted at the different scales and use situations, where the research analyzes the characterizing aspects and hypothesizes spatial configurations of the individual parts also understood as thematic nuclei in themselves, systems within the system, in particularly those potentially more susceptible to heterogeneity and therefore complexity of use.

From this perspective, the entrance and reception space, for example, has

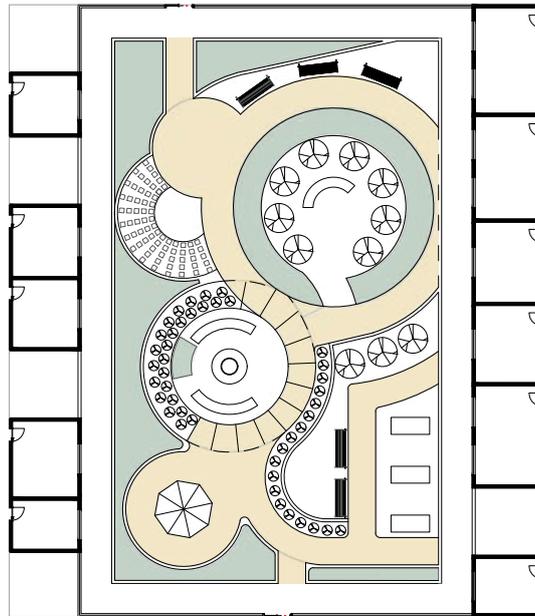


Fig. 9
Healing garden study for the superHub model.
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the fundamental task of interpreting a community reality that combines with the healthcare one, with the need to open the building to the life of a city that finds itself there not only for care needs but also with respect to other needs of strong significance, in terms of aggregation and socio-cultural belonging, which determine the rate of attractiveness of that environment. It is about characterizing a key space where information and initial directions can be provided, distribution to services but also dedicated to meeting opportunities, free time, the increase of social and health culture through exhibitions, conferences, training activities, up to traditional functions of an aggregative nature such as those of a café rather than a themed commercial establishment.

In certain aspects to be understood as a projection of the reception space, the waiting space also emerges in this examination, broken down into the different socio-health services, net of the reduction in times determined by the IT booking systems. The often underestimated condition of waiting also lends itself to finding new situational modalities aimed at the physical and psychological comfort of the different categories of users (adults, elderly, children, people with psychological fragility, etc.) through characterizations of the positioning and shape of spaces designed, as well as colours, images and furnishing components, according to configurations that go beyond the usual room with seats or, even worse, the corridor with a row of chairs at the side. Spaces where the search for characterization of internal landscapes and internal-external visual feedback, starting from the light factor, creates environmental conditions capable of mitigating the feelings of boredom or worry, at variable intensity, of users in a state of waiting.

An overview of the typological components at play which also involves the formal characterization of the distribution spaces (corridors, stairs, elevators); the internal and external green areas near the building with the resulting effects of light, color and diaphragmatic visibility, as well as the recreational and curative practicability; environments with an outpatient function where the duration of daily operations risks affecting the well-being of medical and nursing staff; spaces for recreational and group activities of operators capable of alleviating the psycho-physical stress that healthcare and social assistance activities often cause; the solutions of a signage which is responsible for strengthening the identifiable recognition of the pathways and functional areas. Up to the aspects of an emergency setup

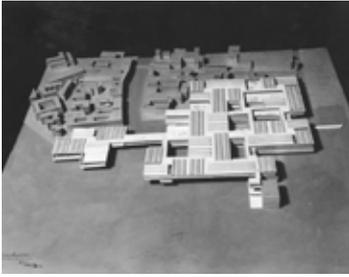


Fig. 10
Le Corbusier, Project for the Venice Hospital, 1964.

where the ability to adapt and prepare the spaces, both internal and external to the structure, can respond promptly and functionally effectively to situations similar to those experienced during the recent pandemic phase. The overall organic structure of the Community Health Centre, to which the complex system of functions and use situations translated into as many architectural characteristics can be traced back, is also prepared for further opportunities for functional complementarity capable of extending the provision of assistance services. In this case it is a question of integrating hospital structures responsible in particular for follow-up courses, the so-called Community Hospitals, to which to add protected residences (in particular for single women and fragile families) or overnight stay and assistance structures aimed at homeless people mansion.

It would be enough to fully and prospectively recognize the importance of the role, the degree of social fruition, the investment in professional and instrumental resources, to establish the need for an architecture dedicated to Community Health Centers as a civil and collective expression that does not may not take on even an iconic responsibility in the city's landscape. However, not so much on the level of a fashionable language or a figuration of appearance, but rather of the character of a structure that measures itself and finds its authentic originality in the relationship with the specificities of the many urban and territorial contexts of application, that is, where the design process, while making use of guidance modeling, leads to an outcome resulting from a detailed dialectic through knowledge of places and cultures. On the other hand, what does Le Corbusier's project for the Venice hospital of 1963 teach us, according to an ideational relationship between typological-functional innovation and the character of urban morphology?⁹

Notes

¹ The Piano Nazionale di Ripresa e Resilienza (July 2021) provided for 15.6 billion for Mission 6 Health aimed at "innovation, research and digitalisation of the NHS" (7.00 billion) and at "proximity networks, structures and telemedicine for territorial healthcare" (8.63 billion) of which 2 billion for the community house chapter then revised in 2023 through the reduction of interventions from 1,350 to 936.

² Adriano Olivetti's humanitarianism emerges in all its complexity in the collection *La città dell'uomo*, published in 1960 (Edizioni di Comunità, Milan), where in the writing *Il cammino della Comunità* he describes the political-administrative, as well as ideal, potential of the phenomenon community in the key of territorial decentralization and solidarity-based provision of public utility services including health and social services.

³ In the premises, Ministerial Decree 77 prefigures a perspective for the healthcare system that "enables the country to achieve adequate quality standards of care, in line with the best European countries and which increasingly considers the NHS as part of a broader community welfare system with a one health approach and vision holistic", in the Gazzetta Ufficiale dello Stato. dated 22.6.2022, page 9.

⁴ In relation to primary care, the European Commission prepared, a couple of years before Covid-19, the Report of the Expert Panel on effective ways of investing in Health (EXPH), Tools and Methodologies for Assessing the Performance of Primary Care, 2018, https://ec.europa.eu/health/sites/default/files/expert_panel/docs/opinion_primarycare_performance_en.pdf

⁵ The PNRR research currently underway is conducted by the UAL Group – Urban and Architectural Laboratory of the Department of Engineering and Architecture of the University of Parma composed of Prof. C. Quintelli (scientific director), Prof. E. Prandi (scientific co-responsible and coordinator of PNRR research), Arch. G. Verterame, Arch. A. Simbari, Arch. S. Taheri.

⁶ Compared to the Agenas document referred to in the previous note, from the point of view of architectural meta-planning, the anticipatory document *Health Houses: regional indications for implementation and functional organisation*, approved by resolution of the Regional Council, appears to be more advanced and of greater design usability. Emilia Romagna n.291/2010.

⁷ There is no consideration regarding the role and architectural quality of the structures built within the *Comparative analysis of primary care in Europe* by Agenas, Monitor 2022.

⁸ Over the last twenty years in Italy, we have witnessed a process of identity revision tending to “humanize” the hospital machine through methodological approaches of Anglo-Saxon derivation based mainly on aspects of a psycho-emotional or phenomenological nature, for example through Evidence-Based Design. In this direction, the research for the Ministry of Health coordinated by Romano Del Nord and Gabrielle Perelli (2012) is emblematic. More recently, also in reference to the needs of a multi-ethnic society, see F. De Filippi, G. G. Cocina, (2021), while the topic of intermediate hospital structures is addressed by Sacchetti L. and Oberosler C. (2022).

⁹ As Francesco Tentori observes, “the French master was the most systematic in his search for the prevalence of voids over solids and, however, precisely in this project for Venice, he clearly reverses the course, also taking inspiration from the Venetian built continuum”. F. Tentori, *Learning from Venice*, Officina, Rome 1994, pag. 21.

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Carlo Quintelli graduated from the Polytechnic of Milan with Guido Canella, and obtained a PhD in Architectural Composition from the IUAV, first cycle 1983-1985. Associate Professor at the Polytechnic of Turin, since 1998 he has promoted the birth of Architecture School in Parma of which he has been full professor since 2001. In 2004 he directed the first Architecture Festival in Italy. From 2013 to 2017 he was pro-Rector for UNIPR Building and Urban Development. Among the publications: *CittaEmilia: unique and multiple in linear urban form*, in AA.VV. *CittaEmilia – the Kent State Forum on the City*, Alinea Firenze 2012; *An urban gate for the University Campus in Parma's Oltretorrente District* in AA.VV. *IP Erasmus*, FAEdizioni Parma 2012; *The Abbey. An architectural project for the CSAC*, Il Poligrafo Padova 2018; *Ignazio Gardella. Other architectures*, with A. Lorenzi, Il Poligrafo Padova 2020, *The urban architectural design that structures the city*. In *The merged city* edited by P. Strina, Il Poligrafo, Padova 2023.

Giuseppe Verterame
The urban role of architectures and places for decentred facilities for community health

Abstract

The recent Ministerial Decree No. 77/2022 has introduced new models and standards for the development of territorial assistance in the National Health Service, aimed at solving the critical issues that emerged during the past health emergency including the Community House. This contribution reflects on the potential urban role of these new structures, where a paradigm shift occurs: from mere buildings providing health services to civil architectures encompassing a significant extension of services directed towards the social sphere. In order to interpret this transformation, the concepts of *centrality* and *urban place* are explored to which the architecture of the *Community Houses* contributes. Subsequently, a methodology is proposed for the urban-scale design of these structures, which are part of a broader system for healthcare and social assistance in the city where, in addition to *Places and Centers for Community Health* as an evolution of the concept of Community House, Neighbourhood Assistance Points are hypothesized, as the ultimate terminals of decentralized assistance.

Keywords

Community — Urban centrality — Urban place — Macroblock

The shock caused by the recent pandemic has generated a common desire for the renewal of social policies, which a necessary advancement can be perceived in. Indeed, between isolation and forced closures, we experienced loneliness, physical distancing with repercussions on behaviors, and consequences on social interaction. At the same time, the period of home confinement highlighted vulnerabilities and strengthened awareness of the importance of personal relationships within communities, organizing actions of solidarity to support the most fragile ones providing food, medicine, and emotional support.

The health emergency has thus highlighted the need to adopt new approaches to achieve a better quality of life, including a paradigm shift in public health «moving from a medical model, focused on the individual, to a social model, in which health is considered as the result of various socio-economic, cultural, and environmental factors» (Capolongo, Buffoli, Brambilla, Rebecchi 2020, p. 271). The sudden spread of the virus led to some of the strictest containment measures in the world within democratic states, adopted precisely because the healthcare system had evident weaknesses in the lack of decentralized support to central healthcare structures such as hospitals themselves.

To rectify the highlighted deficiencies, the Ministry of Health in May 2022, with Ministerial Decree No. 77¹, conceived a new territorial model for the Health Service, introducing the Community House as the focal point of a network of health and social services spread throughout the territory. Derived from the organizational and functional matrix of the Health Houses – which has found uneven application in different regions – it is characterized by an integrated and multidisciplinary approach among professionals in the healthcare, social-healthcare, and social sectors, with attention to continuity of care and home support, particularly for disadvantaged groups



Fig. 1
Carlo Aymonino, “Ecco qua un altro pezzo di città”, 1981.

with new professional figures such as the so-called *Community Nurse*.

This model attempts to respond to the need for a paradigm shift mentioned earlier, which obviously cannot be resolved solely by adopting new models and standards – as defined by Annex 1 of the aforementioned Decree – but through a broader vision, first and foremost one that includes its strategic role towards the city.

For several decades, there has been insistence on the intrinsic relationship between city and well-being and how the quality of life of individuals depends on it, since the United Nations Conference on the Environment held in Rio². Recently, in 2021, the Ministry of Health published the Guidance Document for urban planning from a Public Health perspective, where it highlights that «the concept of the Healthy City presupposes the idea of a community aware of the importance of healthcare as a collective good» (Ministry of Health 2021, p. 6). In this way, the importance of the urban environment for health is highlighted, which is not only associated with the individual sphere but correlated with the community benefit and therefore the idea of community healthcare (ivi, p. 10).

However, the various recommendations contained in the issued documents from the Conference to the recent proposals, have mostly become slogans. Today, beyond some collective facilities, urban renewals of more or less abandoned areas, cycling tracks extensions and low urban impact parks, urban regeneration interventions characterized by a holistic vision capable of restoring a condition of well-being of strong social relevance are not evident. Once again, the health emergency has highlighted issues related to collective facilities and spaces: to many it seemed evident the importance of rethinking the city – during that period denied due to lockdowns – experienced in the vicinity of one’s home to reclaim that innate instinct for community and social expression, often disillusioned because those few and reduced practicable spaces did not have relevant quality.

For community health: the paradigms of centrality and urban place

The need to start from the city as a collective phenomenon and geographical field of community phenomenology seemed evident, capable of – as Jean-Luc Nancy writes – relating singular with plural being, that is, the scene capable of representing the «good show, the social or community being [that] presents itself its own interiority, its own origin (in itself invisible), the foundation of its right, the life of its body» (Nancy 2001, p. 77). Within the necessary paradigm adoptable in the post-COVID context, therefore, the theme of collectivity emerges, a social priority based on the matured awareness of the importance of the role of the community in a solidarity key, as manifested by various entities during the isolation period. The nominalistic substitution from Health House to Community House, although carried out only by Decree without resulting in many contexts in a real change in terms of programming and operational, seems to fall within that matured awareness by the institutions produced during the pandemic to which reference was mentioned above. Considering the present, the advantages of the Community House would be numerous, particularly in relation to themes of inclusion and diversity, solidarity and assistance to vulnerable groups, civic participation and education. Indeed, the community can represent a key element in addressing social, economic, and health challenges, as collaboration and solidarity are fundamental to building sustainable societies in the long term. Adriano Olivetti claimed the importance of the Community within society for the construction of civic sense from the bottom and by focusing on individual responsibility, social solidarity, dignity and rights of individuals, interests of future generations (Olivetti 2013). Olivetti applied community values to different contexts,

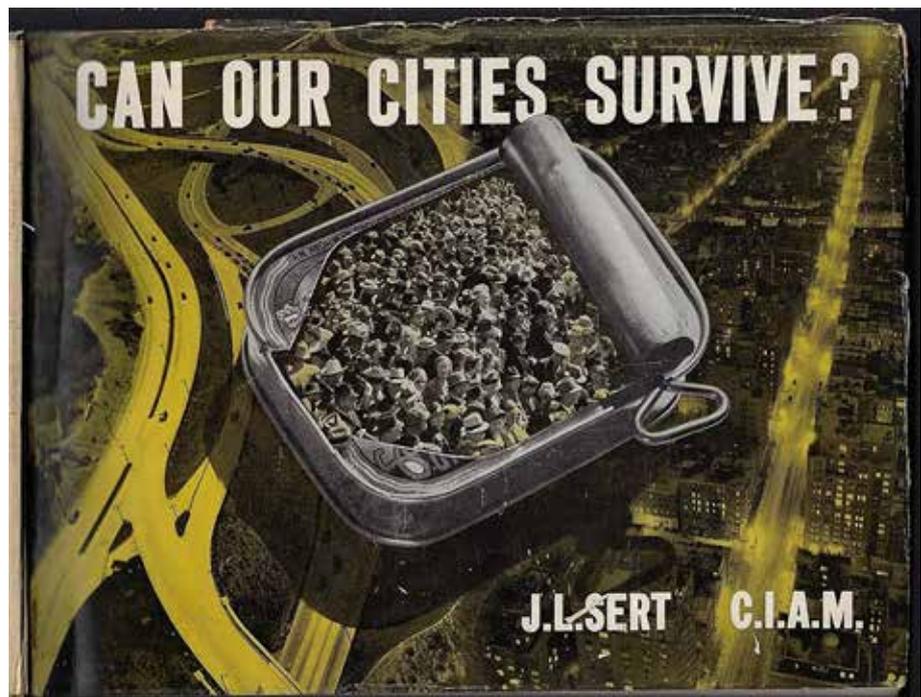


Fig. 2
Josep Lluís Sert, “Can our cities survive?”, 1942 Cover.

Fig. 3
Saul Steinberg, “Piazza San Marco”, 1950.



from rural settlements in Canavese – with the construction of Community Centers – to the industrial work context and up to the development of Ivrea, where he integrated work, residence, and facilities, promoting the construction of houses, schools, and health service to improve the quality of life of employees and their families (Renzi 2008). He unequivocally demonstrated that there cannot be community development disconnected from a place construction which takes to the idea of city, as scene, whilst, of *Communitas* (Esposito 1998) and *Immunitas* (Esposito 2002).

However, among ministerial guidelines, there is no reference to the urban potential of these models of territorial assistance that possess the status of public buildings. The critical emphasis does not aim to be obvious but necessary, considering the meta-design proposals, the initial projects, and the built examples – also including Health Houses – often lacking in terms of typological articulation and representative quality within the urban structure. A forward-thinking and, therefore, sustainable vision must consider the realization of the Community Houses according to the typical collective vocation of civil architecture, interpreting it as the potential community district of a specific part of the city and a means of community phenomenology.



Fig. 4
Ludovico Quaroni and Federico Gorio, with the involvement of Adriano Olivetti, Borgo La Marrella in Matera, 1952-1954.

In addition, architectural and urban mechanism characterized and adequately equipped in this way can play a crucial role in managing emergencies that, as demonstrated in the recent pandemic, are particularly concentrated in urban areas.

Therefore, working on the city with an awareness of the potential role of its facilities can, on one hand, effectively limit the impacts of future emergencies and, on the other hand, underline the central role of the community.

In light of the most significant events, the transformation of the city is conditioned by the urgency imposed by current affairs, such as the necessity represented by community health. According to Antonio Monestiroli, architecture design must experiment with new forms able to reveal the collective reason behind the themes that unfold throughout history (Monestiroli 1979, pp. 34-35).

Given these premises, we should now ask ourselves what the reason for architecture is, in relation to community health, precisely in connection with the city, which, as Carlo Quintelli (2010a, p. 9) believes, should be considered

a community structure, where the mechanisms of reproduction of the whole and its parts tend to reinterpret and reproduce the community principle as a necessary confirmation of the urban background, but according to different declinations and elaborations of meaning.

In this sense, the architecture of community health cannot be dissociated from its collective dimension, without which it would lose meaning.

However, the collective dimension is not solely found in the realization of its practical purposes in response to its main functions, such as those for health, because we would find ourselves with a structure that meets functional and utilitarian requirements but lacks architectural qualities capable of representing its urban role as a civil building.

Thus, in attempting to interpret the meaning of such a work for the community, it is appropriate to delve into what Monestiroli (1979, pp. 34-35) sustains:

«I believe that the reason for every building is based on its function, originates from it, but does not coincide with it. And it is precisely this non-coincidence that allows the progress of architecture, or at least the progress of one aspect of it, that of understanding the meaning of each artifact [...] if we consider function as what links architecture to the concrete reality in which it is built, we can say that knowledge of the function occurs through knowledge of reality as a whole. It is not possible, therefore, to stop at the function as it is, but it is necessary to know its deep aspects, linked to a more extensive and general knowledge of reality. It is this knowledge that allows us to go beyond function and to know the reason for the buildings».

Given certain analytical-critical premises, it is now necessary to proceed

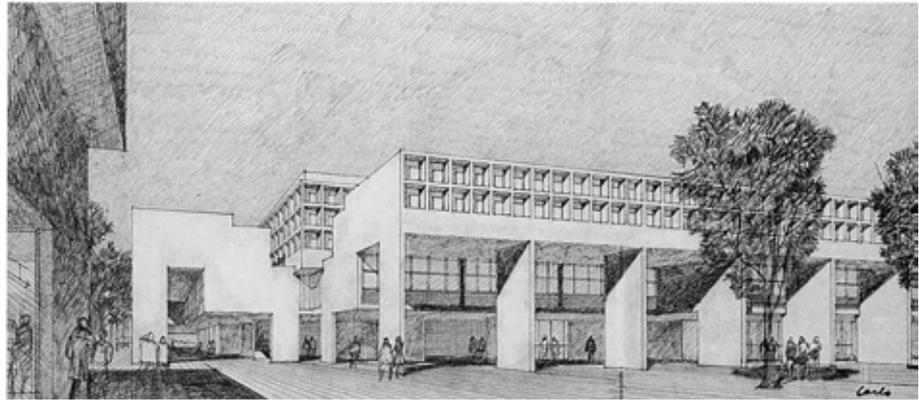


Fig. 5
Carlo Aymonino, School compound in Pesaro, 1974-1978.

synthetically to the design definition, also analogically, of architecture for community health in an urban sense.

If you observe the city – especially the suburbs – a widespread lack of overall characterization emerges, arising from an evident formal indeterminacy. Within a previously determined state of necessity, on the one hand, in terms of urban phenomenology and, on the other hand, sociologically, architecture for community health finds its reason in being able to represent itself as a *factor of urban centrality*³, a collective building, and a composite architectural device, relevant not only in terms of functionality and usability but above all for its ability to interpret its civic sense as urban equipment with predisposition to multifunctionality, flexible in its various uses, easily accessible, endowed with open common spaces, and socially contaminable thanks to the various facilities it can offer.

In this sense, the contribution to the determination of *centrality*, in addition to implementing specific functional programs, can promote exchange and cooperation among various entities and institutions, generating synergies among the actors involved in promoting health as well as social interaction, materializing one of the meanings of community.

The concept of *centrality* is conceptually appropriate both for the scale of architecture and for the city one, the physical context in which the architecture of community health aims to establish relationships. In this regard, we could evaluate the appropriateness of adopting the paradigm of urban place to concretely translate that dimension of *centrality* which architecture contributes to. Indeed, this dual character can represent a plurality of organized forms, such as buildings for various types of activities and services, public or private – including specialized residences – but at the same time expresses a unified image, better able to express its potential urban role as a space for the community.

In this sense, the place represents a complex architectural system, possesses structural and identitary urban qualities, encourages social phenomena, and establishes multiple relationships between architecture and the city. According to Rykwert, the concept of place transcends rational criteria to reach symbolic aspects to the extent that citizens can feel pride in belonging to a certain area, so as to develop a sense of belonging. It is an intrinsic force that influences the sociality of its inhabitants, activating the vitality of a community. Furthermore, he argues that the presence of reference places is crucial because it enriches the urban experience: understood as reference points, they have a significantly urban role and act as catalysts for human activities, to the extent of determining a character, through their representative and distinctive qualities in the urban experience (Rykwert 2003, p. 306).

Drawing from historical experience, the square is the type of urban place that best translates the described qualities: in terms of representation, it is a space endowed with symbolic qualities, identifiable as a catalyzing void of

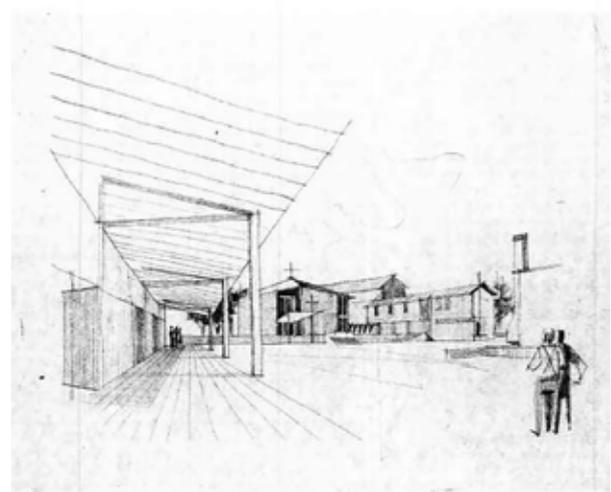
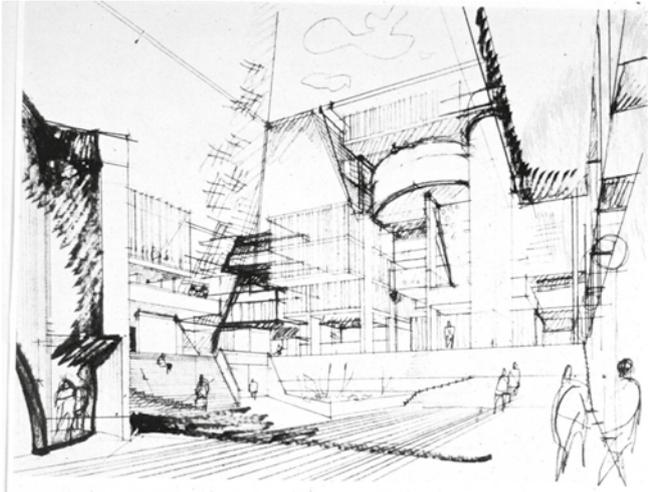


Fig. 6
Carlo Aymonino and Costantino Dardi, Mirano Hospital Competition, 1967.

Fig. 7
Vittorio Gandolfi, Montanara suburb square in Parma, 1956-1957.

public and social activities. In this regard, Paolo Portoghesi argues that it is «indeed the square, understood as the beating heart of the city, the driving force and intellect of the urban fabric [...] the privileged place of encounter, dialogue, and social exchange» (Portoghesi 1990, pp. 13-14). Moreover, he embraces Nancy's thesis on the community's need to represent itself in an urban theater:

«stage and theater enter into the design of the square not as external contributions, but as an inherent requirement of the very concept of square: a place where the presence of man, whether daily or linked to particular events, must become a scene» (ivi, p. 24).

According to Carlo Aymonino, this capability transforms the public space of the square into an urban fact. He demonstrated this in numerous square realizations: surpassing the axiom of empty space, he considered it as «an urban place par excellence» (Aymonino 1995, p.20). He employed one of the archetypal themes of architecture and city construction through the composition of architectural plurality, made up of different but converging parts in the expression of unity, capable of sublimating the concept of place, a conceptual and relational synthesis between urban structure and architectural solution. He made this evident in many of his projects: the realization of schools, residential complexes, theaters, and administrative centers. The importance of his contribution lies in demonstrating that architectural design is not only the solution to a single problem – such as the realization of a building for healthcare purposes – but the response to a complex issue. As evidence of this, for the project of the school compound in Pesaro, he recounts that in the context of the project site, «a central place was missing, organized for civil life, an architecture that represents it» thus suggesting

«to insert a civic, political, cultural, and commercial center in the campus, a meeting place for student segregation and the social reality of the neighborhood [...] a visible and recognizable reference point of that part of the city, undifferentiated in its architectural results» (ivi, p. 54).

To exemplify the structural capacity of the urban role of the concept of place, it may be useful to recall the experience of Ina Casa, without specifically entering into the detail of realized examples. More than half a century later, the architectural and urban quality of those realizations and their ability to become places are still evident. Many constructed neighborhoods, thanks to their layout, have managed to generate significant urban relationships, transforming from autonomous and self-sufficient nei-

**Fig. 8**

Analytical Criterion 1: Endowment and distribution systematicness of Community Health Centers at the territorial and urban scale.

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Fig. 9

Analytical Criterion 2: Position of the area for the Community Health Center.

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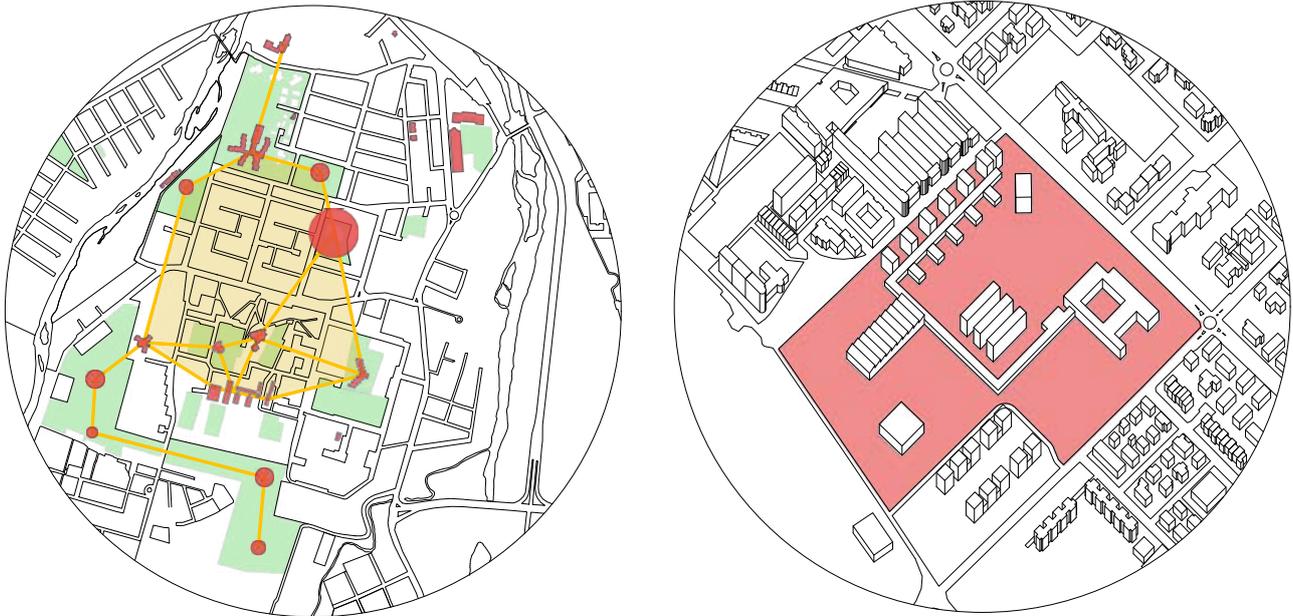
neighborhoods into urban structures, thereby facilitating the construction of new cities around them. This was made possible mainly by the strength of the plural system characterizing the central place of these neighborhoods, where various services, activities, and public spaces converged, capable of triggering identities and strong recognition, even landscape-wise, of that piece of the city (Bocacci 2010, pp. 124-129).

Today, the need to create architectures for healthcare can represent, following the experiences mentioned above, an opportunity to regenerate the suburbs, give meaning to their unresolved fragments, and make them formally complete urban parts. Pre-existing urban elements such as parks, schools, commercial activities, libraries, can synergize with the architectural components of community health to create a strongly denoted place of urban centrality.

Regarding this hypothesis, other scholars, who have recently developed the theme of the Community House⁴, agree on the urban role to be attributed to the new structures to make them «pieces of a regeneration strategy aimed at creating new social networks and, at the same time, capable of substantiating new forms of urbanity» (Ugolini and Varvaro 2022, p. 29-30).

An urban-scale design research hypothesis for Places and Centers of Community Health⁵

To meet the requirements of representativeness, urban structurality, and identity characterization through the adoption of the architectural-urban paradigm described, within the research on new built typologies for community health conducted by a group from the University of Parma, some methodological-design tools are hypothesized to support the prefiguration of places and centers dedicated to these new developments in the socio-health public service. These are criteria and indicators for evaluating the settlement qualities of places and centers of Community Health, supporting their design at the urban scale, even before the architectural one. In particular, this section, included in the ongoing research, deals with the strategic relationship between the aggregate centrality place and the city understood in its structural and morphological articulation of the neighborhood. For this reason, the structural aspects of urban space are considered, especially the ones dedicated to public use and related facilities, designed in relation to other components of the settlement fabric, infrastructural elements, gre-

**Fig. 10**

Analytical Criterion 3: Relationship between centrality factors concerning the Community Health Center.

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Fig. 11

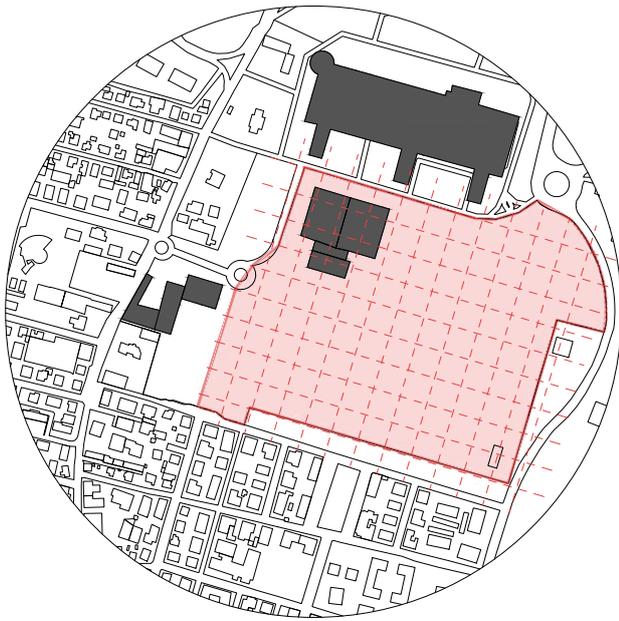
Analytical Criterion 4: Formal identity of the area for the Community Health Center.

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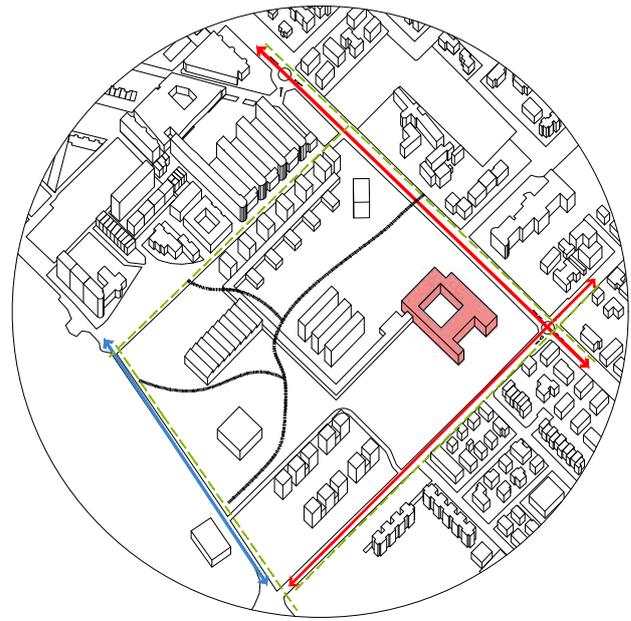
en areas, and large equipped voids of collective and environmental interest. In summary, the methodology outlined within the research evaluates the existing urban conditions and resources, including distributive efficiency, location, relationship with other urban elements, the shape and size of the project site, accessibility, urban planning constraints, and potentially harmful conditions for collective health as well as for the feasibility of implementing the Places and Centers of Community Health.

The methodological tool is developed through the following analytical criteria and evaluation indicators:

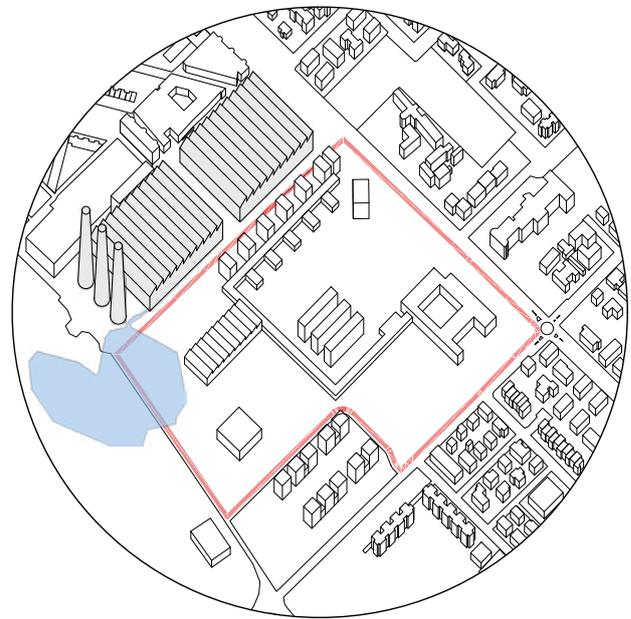
1. Provision and distribution system of Community Health Centers to the territorial and urban scale: this parameter assesses the distribution of socio-healthcare service nuclei at the urban and territorial scale and verifies their distributional balance and capillarity, based on the scale considered.
2. Position of the area for the Community Health Center in the neighborhood/urban area: this parameter highlights the possibility of locating the Place-Center of Community Health in a suitable position – starting from the baricentric one – in order to achieve the necessary accessibility, usability, and recognizability requirements for determining the place and centrality referred to earlier.
3. Relationship between centrality factors regarding the Place-Center of Community Health area: this parameter justifies the positioning in relation to the presence, the capacity for relationship, and prossemic characteristics of pre-existing centrality factors, such as other public services or buildings for collective activities and of strong attraction.
4. Dimensional entity of the area for the Place-Center of Community Health: this parameter verifies the dimensional adequacy of the area in relation to the possibility of settlement in terms of place and urban centrality.
5. Formal identity of the area for the Place-Center of Community Health: this parameter verifies the morphological suitability to capture the functional, representative, and identity potentials, as well as the perceptual relevance of the Place-Center of Community Health.
6. Accessibility and mobility related to the Place-Center of Community Health area: this parameter verifies the presence and effectiveness of various accessibility modes, particularly those of soft mobility.
7. Negative conditioning factors for the healthiness of the Place-Center

**Fig. 12**

Analytical Criterion 5: Dimensional extent of the area for the Community Health Center.
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**Fig. 13**

Analytical Criterion 6: Accessibility and mobility related to the Community Health Center location.
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**Fig. 14**

Analytical Criterion 7: Negative factors influencing the healthiness of the area surrounding the Community Health Center location
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of Community Health area: this parameter verifies urbanistic, environmental, and infrastructural constraints, as well as other harmful conditions for healthiness and the feasibility of implementing the Community Health Center.

These above-mentioned parameters are verified through experimentation on susceptible areas identified within the city of Parma, used as a case study. The exposed succession allows the parametric evaluation of susceptible areas and their insertion into an overall analytical framework from which to deduce synthetically the potential and critical aspects of design application and experimentation.

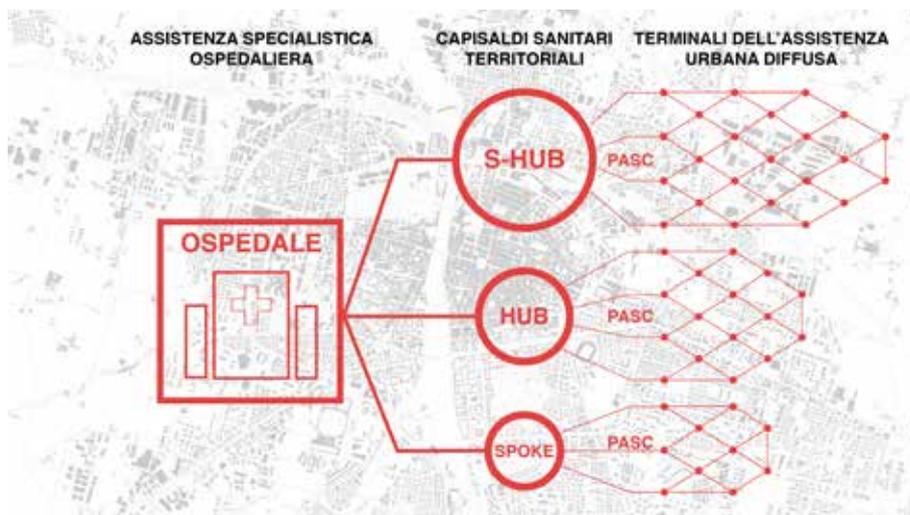
The application of the seven analytical criteria and evaluation indicators produces a ranking divided into four thresholds – negative, sufficient, good, optimal – which allows defining an order in relation to various possible susceptible areas, in order to guide the choices of identifying the areas most congenial to the realization of Places and Center of Community Health.

The Places and Centers of Community Health described so far represent the territorial healthcare cornerstones of a possibly even broader system of healthcare and social assistance within the city, if the adoption of Nei-

Fig. 15

Diagram of the healthcare and social assistance system in the city.

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**Fig. 16**

Within the macroblock: PASC, gathering spaces, and green areas

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Fig. 17

Functional layout of the macroblock. PASC highlighted in red.

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ghbourhood Assistance Points (NAPs) is envisaged, which are terminals of widespread urban assistance. In fact, to meet the need for a widespread healthcare and social assistance system, the introduction of additional facilities is envisaged, spread throughout the living spaces within the urban fabric, to support the higher-ranking structures, namely the Community Health Centers.

In order to analyze and manage the scale related to the urban fabric, it is appropriate to introduce the architectural and urban model of the *macroblock*⁶, useful for the organization and management of a widespread, capillary urban service strategy that is easily accessible from residential areas. The *macroblock* is a unit of the urban fabric obtained by merging multiple blocks – the number can vary depending on the typological-morphological conditions of the blocks and demographic characteristics – inserted into the overall system of the neighborhood. It represents an aggregative principle of the urban organism and constitutes a significant minimum urbanity in terms of demographic critical mass, which, by involving individual housing units at the management level, proposes spaces for socialization, rethinks soft mobility, and experiments with a new organization of neighborhood welfare within it.

The NAPs, which, for its basic operational role, is congenial to the usage physiologies of the *macroblock*, responds to the demand for an observatory as well as for assistance proximity that adequately corresponds to the daily needs of individuals in conditions of health and social fragility, partially self-sufficient and often with limited access to Community Health Centers. The NAPs benefits from the presence of multifunctional concierge services within each *macroblock*, capable of performing additional tasks for



Fig. 18
Architectural and urban prefiguration of the macroblock.
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the urban community, such as reception and information, access control and security, parcel delivery, maintenance and general services, emergency management.

In general, the conditions of services and collective spaces within the *macroblock* counteract physical and social degradation and promote the construction of a cohesive community. Additionally, they improve the quality of life of residents through the introduction of new functions such as playgrounds, gardens, squares, vegetable gardens, and pedestrian and cycle paths. Moreover, the inclusion of assistance services like the NAPs not only contributes to the general well-being of the population but also transforms cities into healthier, more attractive, comfortable, and secure places.

Notes

¹ The Ministerial Decree No. 77/2022 approved by the Ministry of Health provides, for the first time, standards for territorial assistance and introduces new organizational models, including the Community House (Casa di Comunità).

² This is the so-called Earth Summit and the First World Conference of Heads of State on the Environment, held in Rio De Janeiro from June 3rd to 14th, 1992.

³ To delve into the concept of urban centrality, see STRINA P. (ed.) (2023) - *The Merged City: A research on the urban project*, Il Poligrafo, Padua.

⁴ Research “Coltivare Salute.com” coordinated by Michele Ugolini, Maddalena Bufoli.

⁵ This is the progress report of the methodological experimentation of analytical criteria for the urban-scale design of Places and Centers of Community Health, within a research project on urban centralities of community health. The research group Urban & Architectural Laboratory is part of the Department of Engineering and Architecture at the University of Parma, with scientific supervision by Carlo Quintelli, and scien-

tific coordination by Enrico Prandi, along with Giuseppe Verterame, Alessia Simbari, and Sahar Taheri.

⁶ The *macroblock* is developed within the doctoral thesis VERTERAME G. (2022) – *Il macroisolato come strumento della rigenerazione urbana. Spazi, forme e funzioni per la città di medie dimensioni*, Doctoral Thesis, University of Parma, supervised by Carlo Quintelli. For a deeper understanding of the *macroblock*, see VERTERAME G., “The city in quarantine. Perspectives on urban regeneration through the experimental model of macroblock”. In QUINTELLI C., MARETTO M., PRANDI E., GANDOLFI C. (eds.) (2020) – *Coronavirus, city, architecture. Prospects of the architectural and urban design*. FAMagazine [e-journal], 52-53, pp. 113-119, and VERTERAME G., “Interpretations of Centrality: Structuring Fabric Through the Macroblock Tool”. In STRINA P. (ed.) (2023) – *The Merged City. A research on the urban project*, Il Poligrafo, Padua, pp. 192-235.

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Cinzia Badiali, Andrea Donatini, Ambra Baldini
The Community House in the healthcare policy of the Emilia Romagna Region.

Abstract

The article represents the outcome of an interview addressed by Alessia Simbari, curator in this issue of the national-level survey on Community Houses, to the Territorial Assistance Sector of the General Directorate for Personal Care and Welfare of the Emilia-Romagna Region. This interview is the follow-up to a meeting to share the PNRR research underway at the UALab of the Department of Engineering and Architecture on the architecture of Health Houses and Community Houses at a national level.

Keywords

Healthcare architecture — Proximity healthcare — Territorial assistance



Fig. 1
Health House Navile, Bologna.

The Emilia-Romagna Region was among the first to take action on the topic of Health Houses (HH), now Community Houses (CH). Through what assumptions of health culture and administrative choices?

The idea of the Health House derives from two impulses: at an international level, with the orientation received from the Health and Consumers Directorate General of the European Commission (10 July 2014) “Definition of a reference model relating to primary care with particular attention to financing and referral systems” to provide answers to community health problems, through universally accessible services, provided by teams of professionals in partnership with patients and caregivers, providing a central role for the coordination and continuity of care processes; at national level with Law no. 189/2012 and by the 2014-2016 Health Pact, where the task of defining the organization of primary care services from a multi-professional and interdisciplinary perspective is delegated to the Regions. From these assumptions, the Emilia-Romagna Region has undertaken the path of development of the Health Houses, formally established with DGR 291/2010 and DGR 2128/2016.

What overall structure is envisaged between hospital structures and Community Houses in the urban and territorial context? Which good conditions can make it efficient and productive and which ones instead tend to slow it down and bring out critical issues?

The CH are a node in the wider network of health, social and healthcare services and at the same time they are an integral part of the living places of the local community. In this sense, the network in which the CH is in-



Fig. 2
Community House Terre D'Acqua, Crevalcore, Bologna.

serted includes both the services provided directly by the Regional Health Service and those provided by other actors such as local authorities, accredited private individuals, service pharmacies, social and voluntary networks and last but not least the services offered by hospitals. of the territory on which the CH is located.

The organizational model identified by Ministerial Decree 77 to connect services in the area is the Territorial Operations Center (Centrale Operativa Territoriale - COT), which carries out the function of coordinating the care of the person and linking services and professionals involved in the different care settings.

The objective of the COT is to ensure continuity, accessibility and integration of health and social care. All the players in the system (district, hospital and intermediate, residential and semi-residential hospital staff) can request its intervention. This interface process between territorial structures and services presupposes 7-day-a-week operations and the provision of adequate technological and IT infrastructures (common platform integrated with the main business management applications, software with access to the Electronic Health Record, information system interconnected with the Regional Operations Center 116117).

Have you already obtained a significant picture of feedback on the satisfaction of users and operators within the Health Houses or now Community Houses?

To evaluate the HH organizational model in terms of satisfaction, in relation to some quality dimensions (accessibility, relationships with staff, organizational aspects, environments and overall level of satisfaction), between June 2018 and July 2019, a questionnaire was administered to users of Health Houses and Clinics, in which a level of satisfaction was highlighted that fluctuated from 64 to 98% depending on the aspects evaluated, with an excellent evaluation of reliability/trust towards the two types of structure and an excellent overall perceived quality.



Fig. 3
Community House Regina Margherita, Castelfranco Emilia, Modena.

To what extent are the factors of interdisciplinarity and transdisciplinarity reflected within the current organizational structures and working regime of Community Houses?

The CH are healthcare facilities promoting a multidisciplinary intervention model, as well as privileged places for the planning of social interventions and socio-health integration. In the CH, multidisciplinary work is reflected both in the organizational models (e.g. Multidimensional Evaluation Unit, Single Access Point) and with the presence of multifunctional spaces such as meeting rooms, classrooms for training and meetings, which can be used by operators but also for the involvement of citizens.

The development of the use of IT tools will favor interdisciplinary work even when professionals are not present in the same place, reinforcing the concept promoted by the Emilia Romagna region of widespread CH, made up of the set of relationships that exist not only between the network of delivery places, but also between the network of actors and services present in its territory of reference and the community broadly understood as a set of more or less formally organized social networks.

Have the regional administration and the health districts managed, to what extent and through which tools, to operationally interpret the conceptual passage, which emerged from Ministerial Decree 77, which closely links the two dimensions of healthcare and community life?



Figg. 4-5
Health House G.P. Vecchi
Modena.

The CH introduces an organizational model of an integrated, multidisciplinary, proximity approach, characterized by proactivity which is achieved through the operational method of the territorial multi-professional team and by structural participation of the community. To encourage an innovative transition, which does not end in a mere nominal transformation, the Emilia-Romagna Region has launched a three-year training and experimentation path which will involve all the AUSLs (Health Authorities) and all the Districts. The objective is to work on elements capable of generating integration, proximity and participation such as: integrated governance between healthcare, social and third sectors; integrated organizational coordination between social and healthcare; multi-professionalism; participation of citizens, administrators, representatives of the third sector in the processes of reorganization of territorial assistance, identification of needs, design and planning of services, implementation, monitoring and evaluation; adoption and dissemination of an integral approach to health understood as a collective good to be pursued as a community, in all its aspects of physical, mental, emotional, relational and cultural well-being.

How do you evaluate the factor of urban quality, of the architectural structures and environments of the Health Houses, and today of the Community, as a contribution to their community performativity?

The transition from HH to CH has among its objectives that of promoting, at a micro-local level, greater integration and continuity on multiple levels: settings (of care and life), organizational devices, practices and relationships (interprofessional and professional-assisted -citizens). To encourage an innovative transition it is necessary to consider and work on some elements capable of generating integration, proximity and participation as the main directions of health promotion, in many aspects, among which the quality of the architectural spaces of the structures, of the green areas, of public places are fundamental.

What is the current state of implementation of the Community Houses to be built with PNRR funds in ER. also in light of the Government's renunciation of a portion of the expected funding?

Given that at the moment we have no updates regarding the waiver of a portion of funding, we continue with the implementation of the Community Houses through the DGR N. 2221 of 12/12/2022 in line with the objectives of the PNRR and with the Institutional Contract of Development (CIS). To date, there are 132 active Community Houses, following the planning of projects financed both with the PNRR and with other funds, it is expected that, by 2026, 185 Community Houses between hub and spoke will be built in Emilia-Romagna.

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Legge n. 189/2012 e dal Patto per la Salute del 2014-2016,

Regione Emilia-Romagna ha intrapreso il percorso di sviluppo delle Case della Salute, istituite formalmente con le DGR 291/2010 e DGR 2128/2016.

Cinzia Badiali obtained a specialist degree in Nursing and Midwifery Sciences from the University of Pisa and obtained a II level Master's Degree in Management Functions and Management of Health Services and an Advanced Training Course "Management innovation and experimentation of organizational and management models" at University of Bologna. She worked in private and public healthcare facilities as a nurse and subsequently as OU nursing coordinator and manager of both territorial and hospital organizational areas in the City of Bologna AUSL. He currently works full-time in the Territorial Assistance Sector of the Emilia-Romagna Region. She was a teacher in the degree course in Nursing Sciences, module of "Clinical and Rehabilitation Nursing in Chronic Conditions at the University of Bologna.

Andrea Donatini graduated in Economics and Business from the University of Bologna and obtained a Master's degree in Economics from the University of Southampton and in Health Policy from the University of Bologna. He worked for the National Health Agency (AGENAS), for the Social and Health Agency of Emilia-Romagna and for the Department of Health Policies of Emilia-Romagna, mainly dealing with issues relating to primary care and evaluation of primary care. He was Manager of Management Control at the Local Health Authority of Modena and currently manages the Primary Care Area, Community House of the Emilia-Romagna Region.

Ambra Baldini was born in Brescia where she completed her first professional studies and in 2014 she obtained a Master's Degree in Nursing and Midwifery Sciences at the University of Ferrara, discussing her thesis on the topic of Health Houses. She worked in Lombardy and Emilia-Romagna as a nurse and health assistant in the territorial services of the NHS, dealing with the coordination of care and primary prevention activities. He currently collaborates in the Territorial Assistance Sector of the General Directorate for Personal Care and Welfare of the Emilia-Romagna Region. Numerous experiences of educational interventions aimed at the community, planning of events in the health sector in co-planning with public bodies/population groups and teaching in universities and public administrations.

Antonio Nouvenne
Integrating social and healthcare in Community House: what architectural *topos* does the social and healthcare world need?

Abstract

The epidemiological changes of the last decades with the presence of an ever-increasing number of frail and multimorbid patients and the growing social problems of abandonment, loneliness, community disintegration, require a rethinking of treatment paths and structures and a strengthening of social and health policies. The Community Houses, foreseen by Ministerial Decree 77/2022, represent both an opportunity and a challenge. The territory of Parma has developed an inter-institutional project to guide this process. This article analyzes the socio-health context and the architectural-functional needs of the new Community Houses from the point of view of clinicians

Keywords

Community Houses — Multimorbidity — Socio-health integration — Multidisciplinarity — Social pact

In industrialized countries, the epidemiological changes, the improvement of technologies and therapeutic and prevention strategies have led to an ever-increasing number of frail and multimorbid patients, often elderly and with multiple medical and social problems. These patients show a high need for care and present significant connotations of complexity as they suffer from multiple chronic diseases, stable or unstable. They take significant polypharmacy, are dependent on common life activities, live in residential facilities or alone, often with distant family members, cared for by strangers or foreign caregivers with poor empathic relationships also due to a language barrier. The scientific literature is progressively defining this new “biotype” (Realdi et al, Intern Emerg Med, 2011) whose clinical complexity and the absence of specific intra-hospital pathways can make these patients at high risk of becoming “bed-blockers”.

Furthermore, the lack of specific territorial facilities-hospital pathways and often the frailty and lack of homogeneity of the local healthcare network expose this particular category of patients to a risk of improper hospitalization, longer hospital stays, inadequate care settings and further worsening of disability with other poor outcomes, including death (Buurman, Plos One, 2012).

Despite the strong component of frail, multimorbid, often elderly patients in the Emergency Departments, these latter are not always adequate to meet the needs of that type of patient. Generally, in fact, ED are designed and organized primarily to assist people with acute pathologies or serious injuries and not multimorbid patients with functional and cognitive impairments. In fact, the priority in the ED is placed on the speed of triage, which does not allow an accurate evaluation of subjects with multiple comorbidities, with polypharmacy, with cognitive disorders and chronic or

**Fig. 1-2**

A UMM team from Parma (ph. Carlo Cozzoli)

UMM interventions. blood gas analysis and multispecialist home assessment of Covid (Ph. Carlo Cozzoli)

slow-onset pathologies.

From this perspective, and if we add the reduction in hospital beds in recent years, the cultural and management change that is required to the General Medicine and Emergency system become clear: if once the principle was “admit to work”, today we have to deal with an opposite principle: “work to (do not) admit”.

From a social point of view, these changes have reverberated in two clearly identifiable socio-anthropological phenomena: on the one hand, the growth of forms of neo-institutionalization and, on the other, the increase in the phenomena of isolation-abandonment of people and community disintegration. This is evident both in the increase in demand for residential hospitalization places and in growing demands not only for care but also for custody and even containment. On the other hand, we note phenomena such as the birth rate decline, disinvestment in young people, social abandonment, poverty, fragmentation and degradation of the environment. These trends are very dangerous for both people and communities due to the growing resources needed and to the quality of interventions that can be achieved.

In this context, international literature first, and then legislators, identified the need to identify the person’s home as the first place of care and life, connected with the community, services and all sociality. Living in safety, harmony and beauty by enhancing the person, the family, the informal network, with a view to community welfare, allows us to prevent abandonment, isolation and loneliness which represent “per se” risk factors for health. The person’s home must be connected with the Community Home through some Community and Proximity Services. These facilities have to be developed also through an institutional “alliance” between public Institutions, private Stakeholders, “Third Sector” Associations and the participation of volunteers. The initiative and proximity medicine is able to bring multiple social and health interventions to homes, even up to home hospitalization as happens in Parma with the Multidisciplinary Mobile Units and with other projects also through the use of new technologies. At the same time, for diagnostic, therapeutic and healthcare pathways, the person must be connected with the district, Rural hospital, Territorial facilities and University Hospital in order to ensure maximum competence. It has now been demonstrated that an improvement in home care reduces the use of hospital care for the elderly, disabled and mentally ill.

The Italian Ministerial Decree 77/2022 for the reorganization of territorial healthcare activities, has, among its guiding principles, a strong push towards home care and territorial medicine. In fact, the spirit of the legislator was to modify the classic paradigm by moving from the concept of “Healthcare” to the concept of “(protection of) Health/wellbeing” in its broadest sense. From this perspective, the traditional functions of control,

**Fig. 3-4**

Ultrasound and UMM visit in the elderly home (Ph. Carlo Cozzoli)

UMM Parma (Ph. Carlo Cozzoli)

planning and provision of services of healthcare companies have been enriched by proactive, monitoring and management functions, particularly on the social and healthcare side.

Therefore, the design/construction of Community Houses becomes particularly challenging because it requires that the Architect have a multidisciplinary vision of his action which include urban-environmental aspects, urban regeneration, sustainability, architectural composition, aesthetics, biomedical engineering and the social function. And this is even more difficult in the territories where the Community Houses must be created through the transformation of the Health Houses which, essentially, had been conceived with an eminently healthcare connotation, with architectural-functional stylistic features similar to a small hospital or a large clinic. In other words, the required architectural challenge is to build the Community House as a place that contains both highly qualified healthcare functions and social functions of proximity, training and community. The Community House is almost a sort of “third millennium agora”, a place that is experienced in everyday life by the neighborhood, populated by citizens, families, volunteers and professionals from both the social and healthcare sectors.

The Municipality of Parma, to face and overcome these challenges, leading and not undergoing the changes, has decided to engage and reconnect its local community of reference, calling them to sign the “Social Pact for Parma”.

The Social Pact for Parma is an “open” operational document that will be progressively implemented and enriched by new ideas, projects and interlocutors in the coming years. Annual monitoring and qualitative-quantitative evaluation activities will be carried out on the outcomes and objectives achieved. The Social Pact is coordinated by a Control Room, a joint body for the governance of the process of analysis and proposal for revision of existing paths and practices with the aim of facilitating project participation and the implementation of co-programming and co-designs. The Control Room, chaired by the Councilor for Social Policies, is made up of representatives of the top management of University Hospital and territorial healthcare companies, the municipality, the third sector, social cooperation, trade union organizations and other components depending on the needs and projects.

In conclusion, the ultimate objective of the Community Houses is to contribute to strengthening a socio-health pact that avoids anomie and the privatization of suffering, through processes of reception, inclusion, prevention and care that give meaning and value to the person, to the time and to the relationships. It is necessary to integrate the “cure/treatments” centered on the medical, psychological and social components underlying the diseases, and the “care”, the “taking care”, of the suffering, the subjectivity and the needs of the person and his family, always included in the community. The architectural declination of these principles and actions will be the

challenge of the coming years and it will require a process of cultural change that must be improved and must involve many actors: researchers, healthcare professionals, social workers, universities, administrators and politics.

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Alessia Simbari
**Health Houses and Community Houses in Italy:
a first reconnaissance**

Abstract

This article addresses the topic of Health Houses, established in 2007 and subsequently renamed, in 2023, Community Houses, a substantially new typology for which there is a lack of consolidated scientific literature in the sector of architectural and urban design. In this context, despite having thematic and typological analogies, such as hospitals and district health centres, it seems appropriate to review what has been achieved in recent times in terms of decentralized structures and already largely corresponding to the community evolution of the Health House. The aim is to provide a first brief case study of Health Houses and Community Houses already built or in the planning phase in the Italian context, focusing in particular on the analysis of the outcomes in terms of typo-morphological characterization of the built architecture. However, it is necessary to underline that the documentation of the architectural projects financed by the PNRR at present, publicly available, is still rather lacking and therefore susceptible to progressive updates.

Keywords

Healthcare Architecture — Territorial Healthcare — Health House

The concept of Health Houses in Italy originates from the ministerial conference of the same name in 2007, marking the beginning of a path, guided by the amendments to Title V of the Constitution, which transferred competences in the health field to the Regions. Consequently, the Regions have started to legislate on the topic, as demonstrated by Regional Council Resolution no. 291/2010 of Emilia-Romagna, entitled «House of Health: regional indications for implementation and organization» (DGR 2010).

Although only fifteen years have passed since their introduction, in 2021 554 institutions with this name are operational in Italy, a number that is evidently insufficient for decentralized and widespread structures of this type (Pesaresi 2022).

But the paramount issue does not lie so much or only in the quantity of Health Houses at a national level, but rather in their location on an urban and neighborhood scale, as well as in the relationship with the surrounding environment and in the architectural and spatial quality that should distinguish them.

The SARS-CoV-2 epidemic has acted as a catalyst for a profound reflection on social and healthcare structures, revealing their fragilities and indicating the need for new spaces and models of healthcare facilities (Quintelli et al. 2020).

In response to these problems, within the National Recovery and Resilience Plan, the contents of Ministerial Decree 77/2022 are determined and entitled «Models and standards for the development of territorial assistance in the National Health Service» (DM 2022). Planning and regulatory policies that define the characteristics of Community Houses and provide for a significant numerical increase on a national scale.

The National Recovery and Resilience Plan establishes the construction of 1,350 (Italiadomani 2021) Community Houses, which later became 1,430 (Openpolis 2023) following the requests of the Regions, by mid-2026, using both pre-existing and newly built structures, also if, following the revision of the plan in the summer of 2023, the number is reduced by approximately 400 units, thus significantly downsizing the original programming. However, the analysis of the projects financed so far has highlighted the scarcity of qualified architectural projects recognized by critics through publications, underlining the need for a more marked commitment in the design, even before the construction, of these structures to guarantee their success in terms of full achievement of the objectives.

It is important to underline that the presence of Health Houses (HH) and Community Houses (CH) is significantly uneven in the regional geography, with a greater concentration in the northern regions. In this scenario, there is an increase in diffusion in the Emilia-Romagna Region, traditionally at the forefront in the healthcare field.

From the analysis of an albeit limited Italian case study, some significant HH and CH structures have been selected, in relation to which it is possible to highlight some initial aspects of characterization as being of critical importance. The selected structures include: the HH of Carpaneto Piacentino (Province of Piacenza), the CH Ljubljana-San Lazzaro (Parma), the HH of Casalgrande (Province of Reggio Emilia), the HH G.P. Vecchi (Modena), the HH Navile (Bologna), the CH of Predazzo (Province of Trento) and the CH of Salò (Province of Brescia).

The project of the new HH in Carpaneto Piacentino, created by A+C_Architettura e Città associated studio in 2017, envisages its positioning between the historic structure of the former slaughterhouse, whose functional destination currently remains suspended, and the building post office, finding beyond the area involved the spacious Piazza Rossi which, used mainly as a car park, as well as for the market, appears as an asphalted space without a distinctive urban quality in everyday life and with little relevance to the CdS if not in terms of rest area.

The building is characterized by a simple, monoplanar and linear structure, with distinctive elements such as the “L” shape and extended arms that create a suggestive green semi-courtyard of access, highlighted by the significant presence of a pre-existing tree. The linear bodies facing the courtyard, with glass façades protected from sunlight and rain by a projecting overhang, house the entire distribution and waiting system of the structure.

The architecture is inserted into the area in order to facilitate the creation of three green areas and a car park dedicated to staff. Inside, two distribution trajectories intersect in the central corner, appropriately hosting a reception space in that junction, albeit small in size, also intended for an information and waiting desk. A dimensional lack that calls into question the fulfillment of the functions foreseen according to a condition of real reception.

The architectural project underlines the importance of visual comfort and connection with the external environment by users, emphasizing these aspects above all through the creation of widely glazed distribution corridors, according to a language aimed at restoring lightness and formal elegance to that space. The waiting areas are also positioned along the corridors according to an unfortunately consolidated practice, to which is added a lack of attention in the placement of the seats which, oriented with the backrest against the glass, do not allow waiting users to have

**Fig. 1-4**

A+C_Architettura e Città, Health House of Carpaneto Piacentino, Piacenza, 2017.

a view of the space court green. Furthermore, the presence of windows along the distribution space, although it contributes to comfort in terms of vision and brightness, does not guarantee sufficient privacy for waiting users.

Given the limited size of the HH, the flexibility of the building also in terms of expansion is not conceivable except on the Piazza Rossi side.

In the Parma context, the project created by Vincenzo Facchino (S.A.T.) in 2022 for the new Ljubljana-San Lazzaro Community House stands out through an architectural complex divided into four parts, each with a clear functional destination. The first three parts, arranged in an interconnected manner to form a single body with a “C” structure, are designed to host the health activities of the CH and the Territorial Social Centre. The fourth part is identified in a building located behind and independent of the other mainly intended as a Territorial Dialysis Centre, with further spaces dedicated to the 118 Operations Centre.

The central nucleus, identified as the main access point to the structure, houses an entrance characterized by a reception space which includes an information desk and for collecting reports. However, it is clear that the current small size of this space could force users to wait at the entrance door or, on certain occasions, outside the structure, with evident problems of congestion in the access environment. In fact, the lack of reception spaces and services, probably due to a design dated well before the new regulatory guidelines, risks at least partially compromising the very concept of CH.

On the sides of the entrance, the two bodies connected to the central nucleus host, with equal availability of spaces, the component of the Territorial Social Center and the healthcare part. Critical issues related to this

**Fig. 5-6**

Vincenzo Facchino (S.A.T.),
Community House Lubiana-San
Lazzaro, Parma, 2022.

rigid distribution of the operating surface clearly emerge. The social part, represented by the Territorial Centre, enjoys large and comfortable spaces, while the area dedicated to healthcare activities appears undersized and on average crowded. It is a system centered on a single corridor, on average crowded and with little access to the outside, which has dimensions that are not adequate to fully and effectively support the significant and qualified provision of healthcare services present, creating a working environment not entirely optimal for staff, with negative repercussions for users from multiple points of view.

The waiting areas, often obtained from the use of an outpatient module or from the placement of seats along the distribution corridor, further contribute to the problems of use within this area of the complex.

The structure develops on a single floor, built on a previously unbuilt area, free of constraints, and therefore originally susceptible to a high architectural quality system.

Accessibility to the complex is guaranteed both through a pedestrian entrance that leads to the common atrium facing via 24 Maggio, and through a vehicular access that leads to a car park, located on the side towards the north, dedicated to users and staff.

In the formal identity of the structure, an evident semantic discrepancy emerges between the architectural image and the nature of the functions carried out within it. In general, the architectural choices are not concerned with representing the civil and urban value that typifies a Community House even on an iconic level.

The project under construction for the New Health House in Casalgrande, in the Province of Reggio-Emilia, designed by Bertani & Vezzali architects & partners in 2017, according to a typology defined as a “pavilion in the green”, is articulated through the following functional blocks the acute triangle shape of the area. The cellular organic character of the complex derives from the sequence of different elements related through a large and articulated distribution path, which also performs the function of a waiting space, up to the nodal point where the entrance and reception are located.

The structure has differentiated entrances, a main one for the public, a separate one for child neuropsychiatry and a side service corresponding to the driveway access. Volumetrically developed on a single floor, it has a height highlight in the part dedicated to the entrance and reception area. The area not occupied by the building is intended for protected public greenery.

The layout of the clinics and treatment rooms is developed through areas opposite the main access side, guaranteeing reserved and protected spaces. At the same time, the common distribution area for the various servi-



Fig. 7-10
Bertani & Vezzali, Casalgrande Health House Project, Reggio Emilia, 2017.

ces offers welcoming waiting spaces with dual north and south exposure, capable of providing high brightness and visual permeability also from a safety point of view.

Even within a residual space dictated by the road infrastructure, the architects wanted to give the building an architectural and urban identity through a network of functional and urban relationships, stitching together the western edge with the countryside, the nearby rural courtyards, the expansion recent residential area, the distribution avenues and the public and private garden areas close to the historic centre. This texture extends to include the library, the town hall, the theater and the public park, creating a concatenation of urban places integrated into the dynamics of the village.

Currently, the area includes a car park accessible to both users and staff and is served by a cycle/pedestrian sidewalk along the entire Via Carlo Marx, ensuring an excellent connection for low environmental impact travel towards the center of Casalgrande.

The project for the construction of the Health House G.P. Vecchi in Modena, created by Studio Lenzi & Associati and ZPZ partners and completed in 2020, is spread over four functional floors, with a basement and an upper floor dedicated to logistics and plant management. The design approach is based on a block system, highlighted on the ground floor by a vast room, a central “square”, above which, through a vertical hollow space, the different levels are perceived.

The “square” plays a fundamental organizing role in the structure, acting as an entry, sorting and passage point for access to the upper floors, as well as a waiting area for the clinics. This space optimizes the internal distribution of the building and is also an information and orientation point for users.

The reception and related waiting areas are distributed on all levels of the building starting from the “square”, with furnished spaces overlooking the central cavity. A distinctive element is the use of color which varies

**Fig. 7-10**

Lenzi & Associati, ZPZ Partners, Health House G.P. Vecchi, Modena, 2020.

according to its health or social function; this not only facilitates user orientation but also contributes to creating a more “humanized” environment that differs from standardized healthcare facilities historically characterized by poor chromatic variety.

Particular attention is paid to children, with a specifically designed area on the ground floor, near the café, to entertain them while they wait. Furthermore, each floor has seating areas dedicated to the little ones, creating a welcoming environment suited to their needs.

The external formal identity of the building appears semantically ambiguous and partially reflects its healthcare and community function, unlike the characterization developed internally.

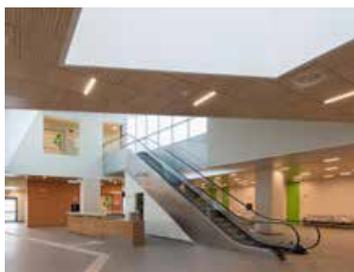
The architectural entity of the Health House in the Navile district of Bologna, built by MATE Engineering in 2018, emerges significantly, almost signally, in the urban landscape, thanks to its volumetric character and the cladding in green panels that completely envelops the entire structure. Distinctive aspects that would like to underline the importance of this large health service center relating to the north-west area of Bologna.

The structure of the Casa della Salute Navile is characterized by a compact architectural block layout, within which, starting from the second floor, an open courtyard cavity is created to provide air and light, while on the first two levels there are determined a central closed double-height environment, including waiting spaces, reception areas and booking services. An arrangement on four floors above ground, capable of adequately organizing the various healthcare and administrative activities envisaged.

The choice to use a sort of covered internal hall as the fulcrum of the activities reflects an architectural approach aimed at creating a single central, welcoming and multifunctional distribution environment, although it presents similarities with the character of a tertiary hall or a commercial mall as highlighted by the presence of an escalator, an element not

Figg. 7-10

MATE Engineering, Health House Navile, Bologna, 2018.



entirely suitable in a healthcare context for functional and management reasons. The escalator, in fact, does not contribute to encouraging physical activity, does not favor access to users with limited mobility and has high management costs that are difficult to amortise in the absence of a strong flow of users.

The waiting space presents a concentration of sessions with inevitable consequences in terms of acoustics, health distancing logics and proximity to outpatient services.

The white porticoed base band on the facade plays an important role in signaling the access points, where the portico acts as a protected transit area and at the same time capable of integrating the building into the surrounding urban context.

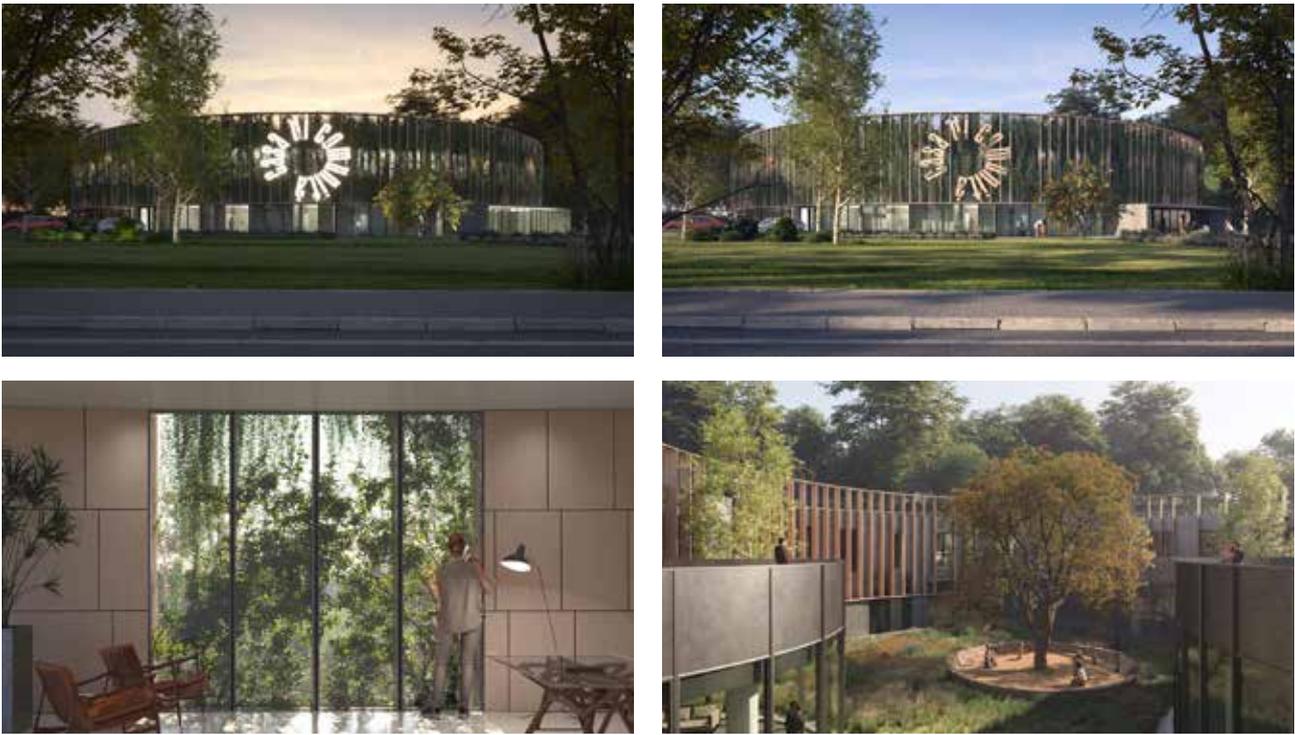
The design approach for the Community House of Salò, designed by Stefano Boeri Architetti in 2022, adopts a circular layout, divided into two levels above ground and a basement. A building also characterized by two distinctive elements: the open courtyard and the green facade, conceived as fundamental landscape features of the project.

The ring configuration of the system marks a onerous route development, according to a single corridor through which to reach the services located at the opposite ends.

The volumes that overlook the open courtyard are intended to accommodate the social, refreshment and waiting areas.

The roof of these volumes is transformed into an open terrace, accessible to the patients of the facility. The court is designed to offer a protected environment, but without covered yet open mediation spaces.

The external facade of the CH of Salò stands out for its large windows which favor visual permeability between the internal and external spaces, thus guaranteeing adequate natural lighting inside the structure, a choice which however must take into account privacy of users and healthcare professionals. The façade is integrated with a wooden structure, anchored to the main system, which acts as a shading and support system



Figg. 7-10

Stefano Boeri, Project of the Salò Community House, Brescia, 2022.

for the vegetation called upon to play a preponderant role up to what is now often defined as a jungle effect.

The project focuses heavily on image, in terms of sustainability and the role of greenery; however, it was contested by the State Superintendency for the protection of the landscape as its implementation would have inevitably led to the “gutting of the wooded slope” in the context of its inclusion.

The last case analyzed in this provisional comparative review, the Community House of Predazzo not yet built and designed by Weber + Winterle architects in 2023, concerns a building project characterized by a block system that emerges through its relevant structure on five levels, including a basement and an attic, from which the extent of the planned functional equipment can be obtained. A building whose image does not capture the need for semantic denotation required by a community-type healthcare facility in the urban landscape, remaining suspended between the idea of the residential condominium and the office building, furthermore devoid of contextual references.

The structure has a main entrance and a secondary entrance positioned on the opposite side, both aimed at facilitating access to the reception space, which, designed to act as a hinge for the entire structure, is however limited in terms of dimensions, resulting proportionally reduced compared to the expected influx of users that the CH should receive.

Defined by the designers as a “hall / waiting space”, this environment, more comparable to a large hallway, is proposed on all floors intended to provide specific services and ends up taking the form mainly as a standardized waiting area, with an acceptance, without adequate differentiation for the different types of users. A key space but without any connection with the outside except for the functions of access and overlooking the street, therefore devoid of characteristics capable of translating situations of a community nature, both functional, perceptive and symbolic.

This is a condition, among others of an architectural nature, which deserves in-depth reflection on the aspects determining user satisfaction within a public service structure such as the CH.

**Figg. 7-10**

Weber + Winterle, Predazzo Community House Project, Trento, 2023.

This first itinerary within the Italian context, although as already mentioned on a necessarily limited sample, has so far highlighted a lack of relevant creations in terms of the typo-morphological and urban quality of the Health Houses and Community Houses built or in the project phase. However, it is possible to identify some recurring critical issues that can be considered paradigmatic, together with some appreciable attempts, regarding the design of the spaces required by the potential of the foreseen integrated services.

From the collection and analysis of the cases carried out, the predominant issues relating to these structures emerge as the pre-eminent question of their location at an urban and neighborhood level, the relationship with the surrounding context, a distribution typology and an iconic definition still not well focused on the functional and identity innovation of the CH. These structures are often positioned within the territory in a random manner, selecting areas available to the Municipality or other competent body, sometimes characterized by limited accessibility especially in terms of cycle-pedestrian paths. Furthermore, they have a poor connection with green spaces and with the places and public services characterizing the condition of urban aggregation. Fundamental public service spaces which thus do not contribute to the processes of concentration and integration of essential services for the city community.

In other words, at times there emerges a lack of awareness of being the House of Health and even more so of the Community, a center of public services which is not limited only to healthcare provision, but which invests in a much broader way in the various needs of the elderly, the disabled, young people, women and families within neighborhood life in the contemporary city.

Starting from this interpretative deficit, it is difficult to functionally re-

present, through architectural forms, the concept of “health” aimed at improving both individual and social well-being. In this context, it is important to underline how the quality of the built space can have a significant impact on the functioning of the services offered and, at the same time, on the sense of belonging, representativeness and inclusion of the citizens who should benefit from the socio-health services according to an approach increasingly oriented towards the community dimension. In the design of social and healthcare facilities, the architect takes on a role of primary importance that extends beyond mere aesthetics and compliance with specific regulations and technical observances. The conception of an optimal care environment requires an approach based on the direct identification of the needs of users, understood as culturally denoted subjects, placing the architect at the forefront as an agent who identifies with the social context in which he operates.

A fundamental perspective not only to understand the functional dynamics, but also to immerse oneself deeply in the expectations and experiences of both operators and patients, from which to derive a logic of spaces that responds in an integral and anthropocentric way to the complex needs inherent to care and well being.

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Sahar Taheri

The international context of Community health centers

Abstract

From the second half of the twentieth century to today, the architectural design of healthcare facilities has undergone notable changes. New elements and value criteria have been added to the architectural component, especially in recent decades, which do not only include form and function. These “new values”, reevaluating past experiences and adhering to a humanistic vision of reality, together with recent technological discoveries and new methods of treatment and care, influence the design choices of contemporary health centers. This article first analyzes some examples of healthcare architecture, in many respects similar to those of the Health and Community House in Italy, from the last fifteen years in the international context. In selecting the cases we tried to broaden our gaze to a global scale and in particular to developing countries, underlining the characteristics and peculiar qualities of these contemporary architectures designed to provide healthcare services close to the population.

Keywords

Health care centers — Healthcare typologies — Architecture for healthcare

In recent times, the theme of architectural spaces for health has received particular attention. The close connection between the design of a decentralized healthcare facility and the social fabric in which it is situated prompts multiple reflections. Just as the dynamic influence of evolving elements triggers the reorganization of design logic and generates new approaches within it, it leads to identifying mechanisms that induce change and promote more dynamic and problem-solving interpretations, capable of anticipating needs and evolutionary directions (Henry, Winkelman. 1972). The construction of basic care healthcare facilities has entered a new phase characterized by the rapid increase in urbanization and the improvement of global medical technology (Li & Yang 2021). The development of the medical model and the expansion of medical technology have led to a greater need for development also in terms of planning and architectural design. The aging population and the increasing quantity and variety of diseases are generating new care needs that must correspond to adequate architectural environments (Li & Yang 2021). With no small difficulty, architectural design, traditionally linked to the hospital typology alone, manages to meet the needs of a health and social development that, by its nature, is influenced by the variables of different local contexts.

In this article, we will attempt to provide an initial overview of the architectural design of such spaces worldwide in recent years, through an analytical perspective capable of highlighting the positive aspects regarding the community significance of healthcare architecture, which goes beyond mere curative medical service. One thing to reflect on is how well the building fulfills its role as a public service in the surrounding

**Fig. 1-2**

MASS Design Group, Family Health Center on Virginia, USA, 2021
Courtesy of MASS Design Group. Image © Iwan Baan

environment. This problem can be examined from three perspectives: first, how architecture morphologically relates to that of the surrounding structures and in general to the characteristics of the place; second, how aware one is of the potentialities of the environment to which the project refers; and third, how suitable and flexible the project is to the requirements and constraints of the condition in which it operates.

Fig. 3-5

estudio__entresitio, Usera, Villaverde and Sanblas, Public Healthcare Center. Madrid (2005-09 Usera; 2007-10 Villaverde; 2005-07 Sanblas).
Courtesy of estudio__entresitio.
Photo credits: Roland Halbe



The first selected case concerns the Family Health Center, Virginia, USA (MASS Design Group, 2021), a surely interesting example in the field of healthcare construction. The project references the typical morphological characteristics of typical single-family houses in American settlement culture while increasing their dimensions. For example, inside, the reception area shows the domestic comfort of a large double-height living room.

The reassuring external appearance reflects the archetype of the house with a sloping roof. Particular attention has been paid to the central reception area as a planimetric node between the two parts of the building. The gable roof of the Virginia Family Health Center is replicated on every part of it so as to be in continuity with the landscape of the East McKinney neighborhood, Texas, enhancing its typified village image. Despite the traditional conception, to allow for future expansion, the building's layout is still designed to develop on the west side of the site (Di Nardo 2021).

This project is a costly investment for the community. Also for this reason, wanting to contain the size of the structure, the project team took architectural cues from the context, including the Dogtrot-style Texan houses that feature multiple buildings connected by a corridor and a common roof. The result is a two-story structure articulated in two bodies, with clinical services in one and community services and facilities for staff in the other.

The project team has changed the way patients experience healthcare by reinventing waiting areas as “different experiences of a home”. The clinic's architecture strongly emphasizes the use of natural light and windows that offer views of the outdoor landscape and natural areas to make patients and their families feel at home. In an attempt to reduce patient anxiety, the number of reception and waiting areas is designed to resemble a domestic environment where dining areas are included, as well as areas for work and play.

The Municipal Health Centers San Blas + Usera + Villaverde, Madrid, (Estudio Entresitio, 2010), are certainly among the most interesting examples in terms of adaptability and compatibility with the built urban fabric, even through the use of a modern language and a particular cel-



Fig. 6
Kaunitz Yeung Architecture, PAMS Healthcare Hub, Newman 2001.
Courtesy of Kaunitz Yeung Architecture. Photo credits: Robert Frith



Fig. 7
ASA Studio, Rugerero Health Center 2017.
Courtesy of ASA Studio.

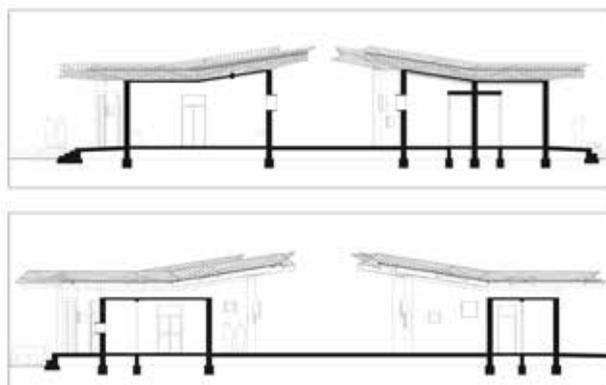
lular structure typology. A trilogy of typological versions that, although sharing the same formal configuration system, are perceived as different. The Sanitary Center called “3*1” is a building based on principles of evident autonomy of spatial form, with a floor plan similar to that of the other cases but made with different materials and where the light predominantly comes from above. In fact, each of the three Centers is developed on a single floor with a mix of spaces open to the public and operational illuminated through the modular arrangement of several small courtyards. For further aspects, reference is made to the descriptive intervention of Estudio Entresitio present in this issue of FAM.

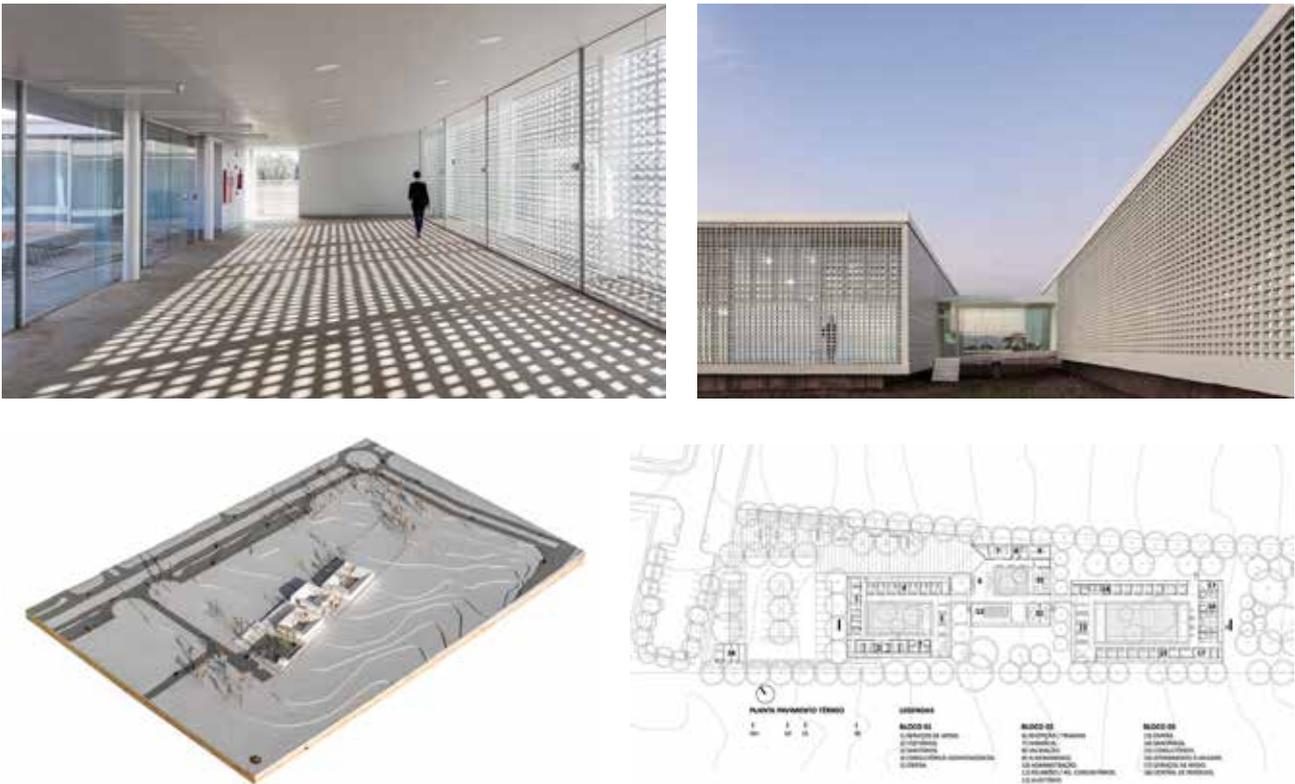
Another example of a typology linked to environmental factors is that of architecture that derives distinctive elements from the culture of indigenous populations in native areas. One of these buildings is the result of the Pams (Puntakuru Aboriginal Medical Service’s) Healthcare Hub project in Newman, Australia (Kaunitz Yeung Architecture, 2020), in a region where the presence of the Aboriginal population prevails. Although this building has been constructed in recent years, instead of a design derived from Western characteristics and patterns, the designers attempted to create architecture adhering to indigenous reality using formal references, symbols, and building materials from the local culture. The aim of the designers is also to create a construction whose realization is economical but aesthetically valid and distant from the references of standardized architecture albeit of high quality. For further aspects, reference is made to the descriptive intervention of Kaunitz Yeung Architecture present in this issue of FAM.

The Rugerero Health Center, Rubavu, Rwanda (Activesocialarchitectu-



Fig. 8-10
Kéré Architecture, Centre for Health and Social Welfare, Laongo, Burkina Faso 2012-14.
Courtesy of Kéré Architecture.



**Fig. 11-14**

Saboia+Ruiz Arquitectos, Primary Healthcare Center - UBS Parque do Riacho, Brazil 2021. Courtesy of Saboia+Ruiz Arquitectos. Photograph: Leonardo Finotti

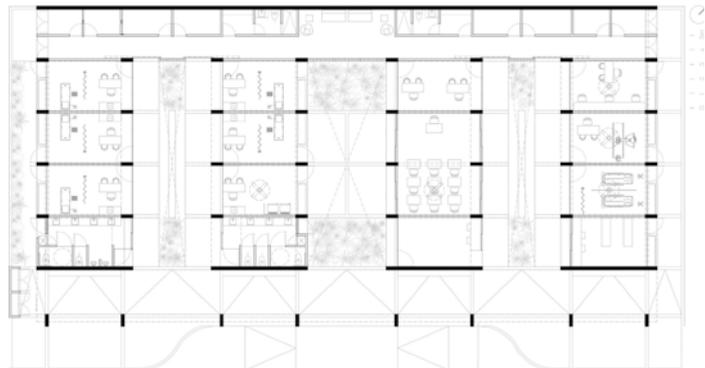
re, 2017), is another example of a decentralized healthcare nucleus conceived for the local population. The intervention, in the African environment, stands out for how it draws elements from the variations present in the culture and typology of local settlements. The structure encompasses some basic hospital activities, thus defining an important community reference center. It takes on the typical form of public space within a village, with distinct elements designed to promote urbanity through the design of an aggregating open space. For further aspects, reference is made to the descriptive intervention of ASA Active Social Architecture present in this issue of FAM.

Also in Africa, another project of significant interest concerns a surgical clinic and healthcare center in Léo, Burkina Faso, designed by Francis Kéré (2017). This architect, born in West Africa with university education in Europe, seems to want to express optimism even in the most difficult housing and social conditions, demonstrating that the realization of democratic and universally valuable architecture is possible (Baratto 2022).

The project creates an inclusive atmosphere of healthcare institutions using ten modular units for dynamic and welcoming spaces, reducing costs and speeding up construction. The clinic has a simple but efficient modular layout that allows for growth. The building is developed around an external central corridor that mimics the typology of the road passing through the inhabited center.

The units are equipped with large overlapping roofs to efficiently collect rainwater, thus ensuring one of the fundamental prerequisites for health and well-being in a region with only three months of rain per year (Kéré 2014).

In the UBS Parque do Riacho Primary Health Care Center in Brasilia, (Saboia+Ruiz Arquitectos, 2021), inserted into the broader context of that capital city which interprets the modernist language, the project develops

**Fig. 15-17**

Kiltro Polaris Arquitectura + JC Arquitectura, N1 Health Center, Escárcega, Mexico, 2022.

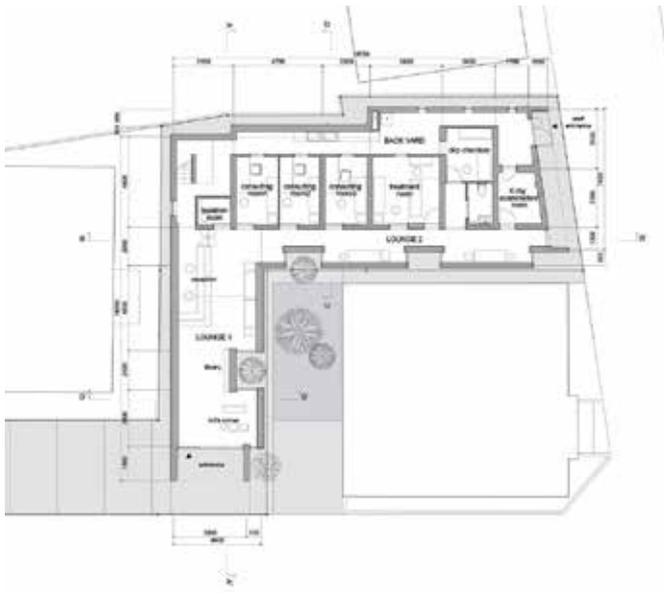
Photograph: Cesar Béjar, Oscar Hernández

from an introverted logic layout formed by the repetition of courtyards connected by a covered path, each of which is assigned a specific function. The courtyards determine protected spaces from the strong winds of the region, also providing shade and isolation from the outside. Great importance was given to the theme of waiting rooms in this solution, despite being designed before the Covid-19 pandemic, as the connection of the courtyards with the waiting rooms ensures optimal ventilation.

The complex presents undeniable architectural and aesthetic quality through spaces characterized by transparencies and diaphragmatic effects between interior and exterior, with shadow play caused by the particular sunshades on the facade. In fact, it is a double-layer facade so as to create an intermediate space used as a corridor for connecting medical studios and other service spaces (Moreira, 2021).

Another interesting case from various perspectives is the N1 Health Center in Escárcega, Mexico (Kiltro Polaris Arquitectura + JC Arquitectura, 2022). It has been designed on a single level, taking into account the climate and local housing culture, which have led to the adoption of outdoor waiting areas protected by the overhangs of the roofs capable of providing substantial shaded areas. The layout design is comb-shaped, with open courtyards alternating with enclosed volumes. Although the distribution paths are external, they are protected from the sun thanks to the cantilevers of the concrete roofs. The rationality of the typological structure combines with a language of constructive essentiality that effectively interprets the public function of the structure.

The healthcare architecture of the Centro de Salud N1 reveals a certain brutalist declination in terms of language, using modern materials such as reinforced concrete and designed structural elements. The intervention ensures that the 798 sqm area is adaptable to the diverse needs of

**Fig. 18-20**

hkl studio, Asahicho Clinic, Chiba, Japan, 2015.

Photographs: Shinkenchiku Sha, Tetsu Hiraga

contemporary Mexican mid-sized cities (Maju 2022). The logical clarity and simplicity of the Centro de Salud N1 are evident in the way the architects describe the project: “It is a clinic open to the city and, through a series of versatile recesses and central courtyards, it offers access to basic health services” (Kiltro Polaris Architecture + JC Architecture).

In the context of the Far East, we find the Asahicho Clinic in Chiba, Japan (hkl studio, 2015). An undisputed example of aesthetic, typological, and functional quality that subtly integrates among residential buildings, adapting to the high density of the morphological fabric typical of many Japanese urban contexts.

This medical center is designed to blend in with the surrounding residences on the outskirts of the city using a plastic conformation based on the silhouette of a linearly replicated house. Almost to disguise the size and function of the building, the Tokyo architect has created a sequence of sharp arches of varying heights that resemble the pediment of a house. This technique has been frequently used for healthcare buildings (Mairs 2015). The examination rooms are positioned at the back of the building, in the arm parallel to the street to allow for greater privacy, while a double-height reception space occupies the wing of the building perpendicular to the street.

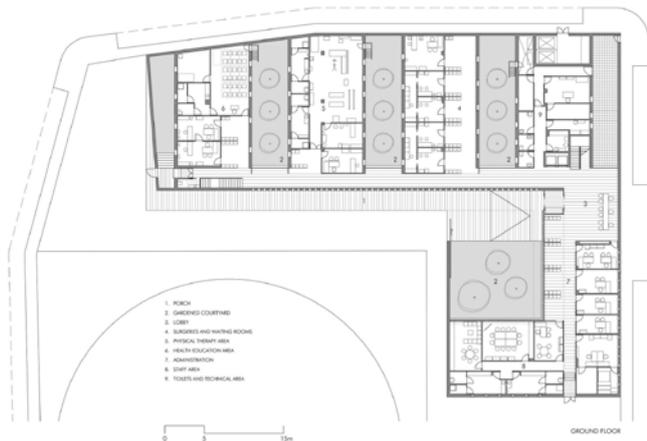
The transition from the welcoming entrance to the waiting space unfolds at double height and reduces the feeling of pressure from the dense surrounding environment.

Another interesting project concerns the Gibrleón Health Center in Gibrleón, Spain (Javier Terrados Estudio de Arquitectura, 2020), built to

Figg. 21-22

Javier Terrados Estudio de Arquitectura, Health Center at Gibraleón, Spain, 2020.

Photographs: Fernando Alda



provide a tranquil and protected environment in the peripheral area of this Andalusian town, incorporating plastic values of a Mediterranean-toned urban architecture. The project was influenced by the “L” shape of the plot and the adjoining outdoor amphitheater of strong collective significance, considering the location at the southern limit of the city center. The approach path is defined through a slight setback of the facade on the western side of the building constituting a protective portico.

The citizens were indirectly involved through a department of the Ministry of Health of the regional government, which collected issues related to the performance, requests, and complaints of existing health centers and their users. The functional program was developed by public employees working at the Ministry of Health, considering the demographic profile of the area and medical specialties.

The design process focused on a basic layout with a clear circulation scheme, a progressive gradient of privacy, and flexibility in the use of outpatient and office spaces. The center was built using a standard brick-clad envelope with a cement/double-layer structure due to budget constraints (Javier Terrados Estudio 2023).

The Nye Vardheim Healthcare Center in Randaberg, Norway (NORD Architects + 3RW Architects, 2014-2020) draws inspiration from the urban character of the old type of Norwegian village called Grend, combining various healthcare programs and functions that, through green courtyards for a welcoming pedestrian pathway, are placed in a small group of houses capable of conveying the sense of a micro-community.

The center offers a wide range of functions, including elderly residences, medical visits, and therapeutic activities, and is realized through a plurality of buildings with a solid construction consistency using natural stone. The complex envisages aggregation between the built parts through courtyards, recreational gardens, and greenhouses, thus creating an

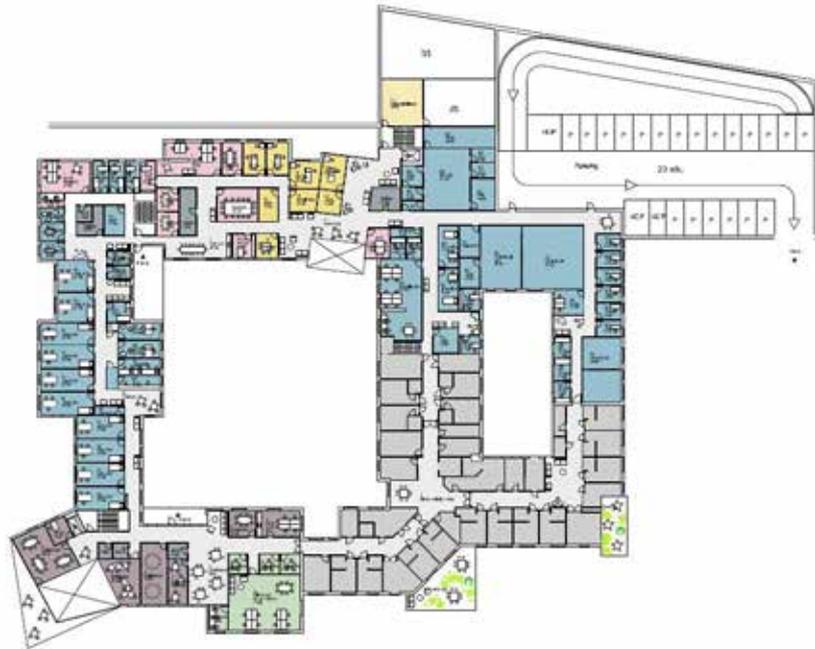


Fig. 23-25

NORD Architects + 3RW Architects, Healthcare Center in Randaberg, Norway, 2020.
Courtesy NORD Architects + 3RW Architects

atmosphere denoted by greenery and warmth (NORD Architects).

Future institutions will draw inspiration from this concept of a village that combines the therapeutic facilities of a large complex while reproducing the sense of well-being of a home (Aasarchitecture 2017). An intervention that has become a reference point for the municipality and a new way of developing and rethinking healthcare institutions in modern welfare societies (Nye Vardheim by NORD Architects 2014).

The currently unrealized project of the Urban Community in Thessaloniki, Greece (Fiore Architects, 2019), is an example of integration between different functions in the urban context capable of creating a neighborhood center.

The aim of the municipal authorities was to redevelop an urban area to create a functional and aesthetically pleasing system of buildings, aggregated through the longitudinal space of the pedestrian street, satisfying the needs of residents and creating a public green space. The building complex aimed to be a model for the organization of public functions, including healthcare, in open dialogue with the city to which they are intended.

**Fig. 26**

Fiore Architects, Healthcare Center in Thessaloniki, Greece, 2020.
Courtesy Fiore Architects.

The project aimed to create an urban landmark, a public intervention mindful of the historical past of the Toumba neighborhood and at the same time of its modern, lively face as a city area. The concept of the urban center is interpreted through the aggregation of service buildings, designed to function together and independently, contributing to facilitating accessibility for residents, especially the most vulnerable including people with disabilities. The project also aimed to requalify the urban landscape and contribute to urban greenery, inviting visitors and the local community to interact and work together (Fiore Architects, 2023).

In conclusion, among the examples we have briefly analyzed, some use the metaphor of the house as a semantic matrix of the project, including the Virginia Health Center, Randaberg, and Asahicho Health Center. Others have developed their role at the micro-urban scale, integrating various functions and attempting to create a neighborhood center for local residents, as in the Urban Randaberg center, Thessaloniki, or the health center in Burkina Faso. Further projects have fundamentally worked on the architecture of a single building, albeit through articulated typologies, based on an innovative and avant-garde definition of a community-oriented health home, as in the cases of Madrid but also Gibrleón in Spain and Brasilia, or on the correct interpretation of the culture and climate of a region, in various ways as in the cases of the Mexican N1 health center, the Pams clinic in Newman, or the Rugerero Health Center in Rwanda.

All these examples confirm that international design research on this topic is at the forefront and remains in progress. It is not surprising that South African architects are using artificial intelligence in their projects, in an attempt, perhaps only seemingly paradoxical, to decolonize the country's architectural heritage to incorporate indigenous culture and traditions (Dirk et al. 2023).

As intermediaries between the home and the hospital, community health centers are essential in the care chain. In the future, their importance in rapidly changing healthcare systems is expected to increase. This poses a series of new problems and questions for architects tasked with designing these healthcare facilities in addition to hospitals. A perspective that motivates the experimental choices made today capable of shaping the healthcare and assistance expectations of the society of the next twenty years.

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Sahar Taheri (1983), is an architect and second year doctoral student in the Department of Engineering and Architecture of the University of Parma. He completed his Masters in Architecture at the University of Parma, ITALY with a thesis entitled “From the urban void to the urban stage” and his degree in architecture at the University of Tehran, IRAN. He has practiced in numerous roles with architectural firms and organizations in Iran, where he obtained his license as an Architect in Construction Organization.

He also has two papers published in the international conference on Architecture, Civil Engineering, Urban Development, Environment at Tabriz University of Art, Iran, 2022. His current doctoral research focuses on designing new typologies of healthcare architecture after pandemic (research funded by the PNRR).

Florian Giannis Liakos, Irene Helen Marcantonatou,
Alexis Visvinis (FIORE architects)
An urban complex for welfare services in Thessaloniki

Abstract

The article is a report of an interview conducted by Sahar Taheri with Fiore Architects studio, the author of a project for an urban complex for welfare services in Thessaloniki. Embracing various public functions and green spaces, the project aims to serve as a landmark and meeting place, bridging the gap between the historical past of Toumba and the modern urban identity. The complex, the result of a collaborative workshop, hosts various facilities, prioritizing spatial autonomy and flexibility. A central pathway connects eight independent units, fostering interaction and serving as a dynamic public thoroughfare. The complex meets inclusion requirements, providing cultural and social assistance facilities and positioning itself as a community center.

Keywords

Community Service Center — Co-design — Welfare Architecture

How was the project area chosen?

The project area was identified by the Municipality of Thessaloniki as the property is owned by the municipality and currently houses a small 19th-century building. In recent years, the local authorities have planned the reconstruction of the site in order to create a building complex that would functionally and aesthetically meet the needs of the residents while also providing a “Public Green Space.”

What other service structures in the urban context were considered?

The main objective in designing this proposal was for the building complex to adopt a model for organizing various public functions in such a way that they engage in open dialogue with the city. Therefore, creating a landmark, a public project that becomes the meeting point between the historical past of the Toumba neighborhood and its modern identity as a lively urban neighborhood. Last but not least, the concept that inspired this project was that of an “urban neighborhood,” where the various units are placed in such a way that they can work together while remaining independent, thus contributing to mutual benefits for the residents.

What factors and forms of the urban area in which the project is located influenced the design choices?

The concept of the final synthesis was to design a small urban community, where eight independent building units, in addition to the nursery, coexist harmoniously, while passages between them allow free circulation and direct access to them. The central pathway, which runs longitudinally through the plot, serves as the unified basis of the entire architectural layout. Although the eight building units serve different public needs, they



Fig. 1
 FIORE Architects, Urban complex for welfare services in Thessaloniki, 2019. Insertion into the urban context.
 © FIORE Architects

were designed with the same architectural vocabulary. In this regard, the main objective of the proposal was to both elevate the urban landscape to a good aesthetic level and to provide a concrete contribution to the creation of necessary green space.

Were citizens involved during the planning phase? How?

In March 2015, the Municipality of Thessaloniki, the 4th municipal district (Toumba neighborhood), and the School of Architecture of AUTH (Aristotle University of Thessaloniki) organized a workshop entitled “A courtyard for the neighborhood.” Together with the residents of Toumba, they aimed to reintroduce the values of the place and to promote the integration of asylum seekers into the social system.

What was the contribution of health and social workers during the design phase? (doctors, nurses, social workers, etc.)

During the planning phase, various meetings were organized in collaboration with the Municipality of Thessaloniki, with associations and presidents of social service administrations, such as the community health center, the municipal gymnasium, etc., in order to outline a strategy according to the needs of each service. Subsequently, in the design process, a meeting was held on space characteristics and function allocation.

How was the functional program defined?

The building complex has the potential to include various public welfare uses in such a way that they engage in open dialogue with the city and the people they serve. In this framework, the needs of residents of a larger area are met, bringing them together for common activities and aggregative occasions. Specifically, the intervention includes: a nursery, housing for asylum seekers, an indoor gym, a multipurpose hall for social events, an outdoor cinema, a memorial museum space for Toumba refugees, community municipal offices, a community health center, a day center for the elderly, a playground, and a small neighborhood park. The total land area is 3800 sqm, and the final building area is approximately 4500 sqm.

What typological and formal criteria were considered?

The exterior cladding in bricks was chosen as the base material for all building facades. It is a material that automatically refers to the long tradition of tile usage in the construction of the city of Thessaloniki and, more

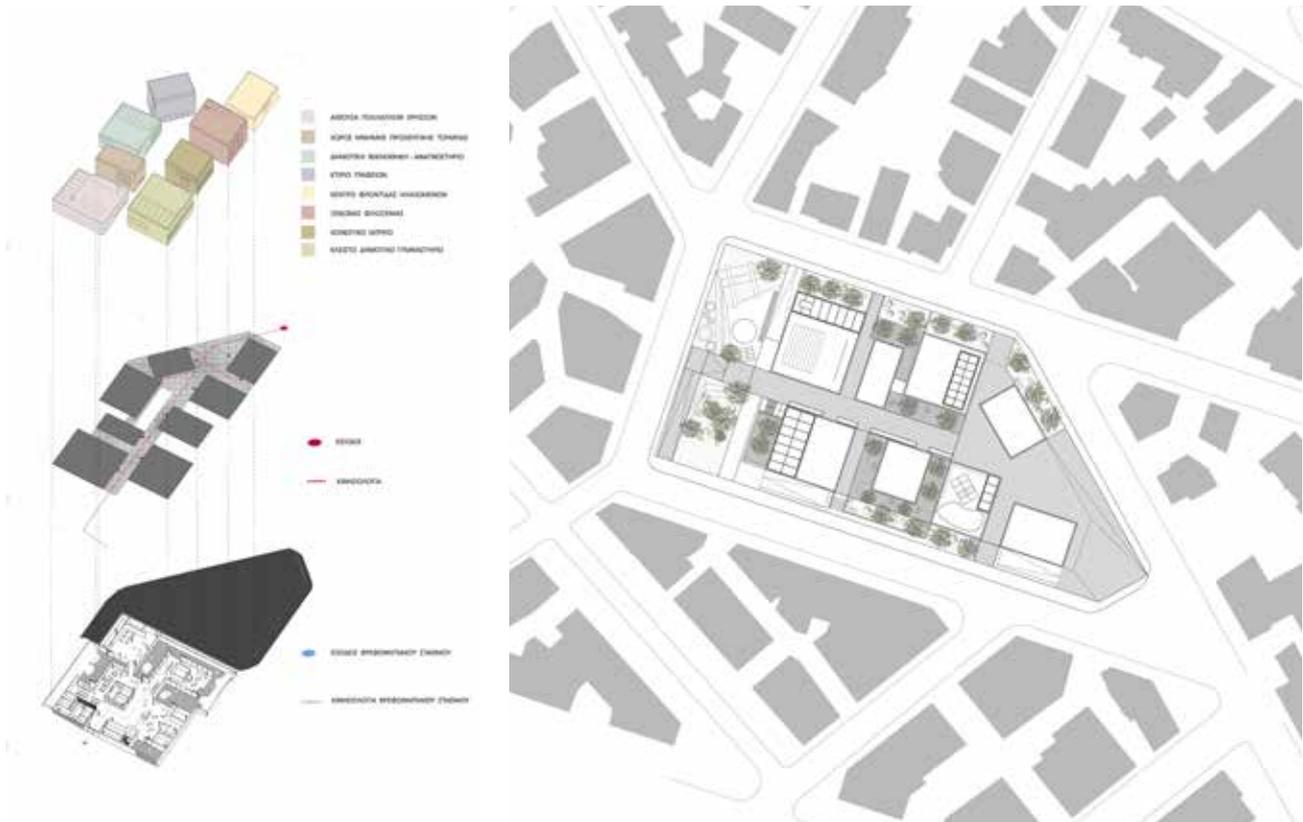


Fig. 2-4

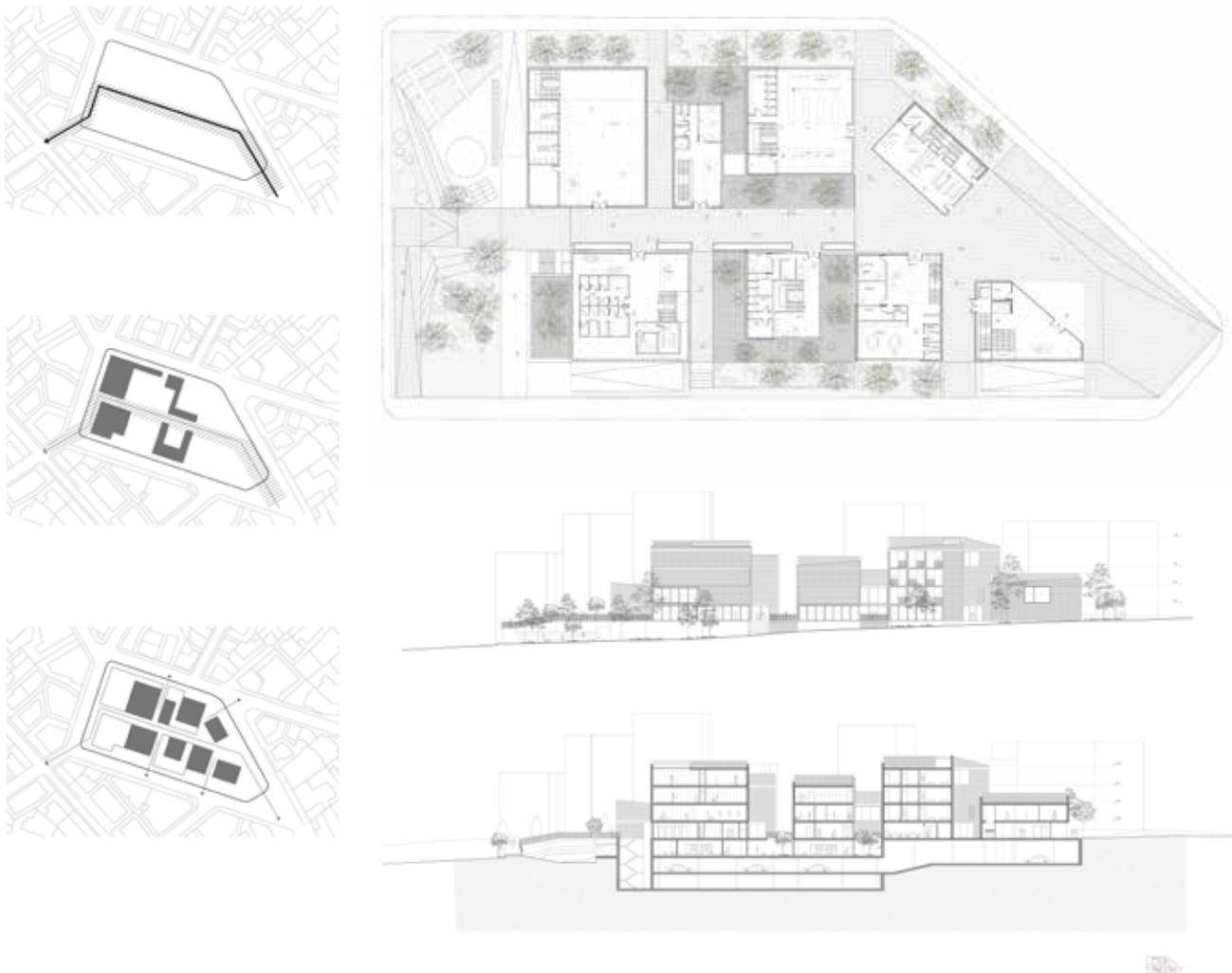
FIORÉ Architects, Urban complex for welfare services in Thessaloniki, 2019. Functional diagrams; General planimetry; View of the complex from above (render).

© FIORÉ Architects

specifically, to a material that is indissolubly linked to the early light constructions for refugees in the Toumba neighborhood. These constructions were the reference for the cluster technique, which was translated in the present proposal as a morphological element of the building facades in building blocks.

What are the main features of space articulation?

Placing the function of educational services as a starting point for the composition of the complex conceptually emphasizes its crucial role as the individual's first point of contact with public life. At the same time, on the design level, this planar organization of the interior spaces also allows direct contact with the natural environment. The entrance is located to the west of the plot, from the shared pedestrian passage on the side of the playground. For the rest of the complex's kinesiology, the main entrance to the functions is from the east side of the ground to avoid interference between all users and those of the nursery. Therefore, the buildings on this side (the

**Fig. 5-7**

FIORE Architects, Urban complex for welfare services in Thessaloniki, 2019. Diagrams; Ground level plan; Elevation and section.

© FIORE Architects

nursery, for the elderly, the information point, and offices) are arranged parallel to the directed form of the plot. Among them, a common passageway is determined, which essentially “welcomes” the visitor and directs them towards the longitudinal axis that structures the overall layout.

What role does the concept of hospitality play in the project?

One of the main reasons for the proposal was to design in exemplary terms a complex that could “invite” visitors and the local community to meet and perceive public space as a space of vital importance.

What criteria and technologies were used in the project to address the issue of climate change?

First and foremost, through correct positioning and orientation of the building on the ground. Moreover, the design included necessary openings to ensure adequate external lighting, good natural ventilation, and solar protection during the summer period. Therefore, the arrangement of the real estate units, on both sides of the public pathway, took into account the needs for better ventilation and solar radiation of the entire building complex. In this regard, we modeled the surrounding area to improve overall microclimatic conditions. We also plan to plant 26 trees on-site, and 2/3 (about 1500 sqm) of the free space of the land is allocated to “Public Green Space.”

What is expected in the future regarding the architectural design of healthcare centers?

The needs of modern society are constantly increasing, especially in the

**Fig. 8-11**

FIORE Architects, Urban complex for welfare services in Thessaloniki, 2019. Internal and external views.

© FIORE Architects

most populous cities. Therefore, it will become increasingly necessary for designers to be aware of providing spaces that truly meet the needs of inhabitants.

What are the key factors in designing a healthcare building?

The key factor in designing a healthcare building is to aim for an open building complex that invites residents and makes spaces more intimate. Healthcare and social buildings should be designed to incorporate the fundamental dimension of inclusion and a sense of belonging, creating an aesthetically characterized building ensemble that positively predisposes visitors and familiarizes them with the entire surrounding environment.

Is there a unified model for addressing this issue?

Each project is unique because it addresses different societies. In every project, many factors must be taken seriously into consideration, and every answer lies hidden in the needs of society.

Can design and architecture contribute to patient healing?

We believe that patient healing can be sought beyond medical contribution. When a space is designed to be freely used by city residents, so that they can be mentally and physically cared for through various activities, then therapy is not one-sided, and therefore yes, spaces created by architecture can be extremely useful for all types of patients.

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Florian Giannis Liakos, Irene Helen Marcantonatou and Alexis Visvinis founded the architecture team FIORE Architects in 2015. They studied Architecture at the National Technical University of Athens. The team was initially created to participate in international architectural competitions, where it obtained numerous awards and mentions. Subsequently, they have carried out small-scale residential projects and small-scale renovations both in Greece and in Saranda, Albania. FIORE Architects have also collaborated with Greek architecture firms on large-scale projects.

Maria Hurtado de Mendoza (estudio_entresitio)
Indifferent to the place: an architectural type for Madrid

Abstract

The text is the result of an interview conducted by Sahar Taheri with the studio.entresitio regarding three healthcare centers in Madrid, called '3*1'. They share a common form despite being located in different urban contexts. Thus, the three centers embody a strategy of a 'placeless building', offering formal autonomy and conceptual flexibility. The concept of 'programmatic bars' is introduced, emphasizing aggregation rather than division in the design of the healthcare program. The trilogy represents innovative design approaches, reconciling opposites and creating coherent and adaptable healthcare structures.

Keywords

Health centers — Formal autonomy — Project

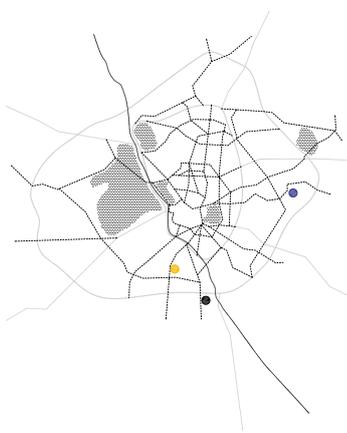


Fig. 1
 estudio_entresitio, 3*1, Health care centers in Madrid. Urban location design.
 © estudio_entresitio.

Through what criteria was the project area chosen?

3x1 is a trilogy of health centers that estudio.entresitio created in Madrid. The reason why there are three may not be factually relevant. It all started with an unusual competition to build two clinics for the same client (the municipality of Madrid) with the same budget, the same functional program and on two different sites.

Our response to those initial conditions was to work with the idea of a “placeless building” as a strategy for inserting a cohesive whole into irrelevant environments. A great sense of autonomy was needed in formal, functional and even conceptual terms to allow the building to exist anywhere. This so-called placeless building takes the opposition between hermetic and open as the conceptual framework and initiator of the project.

The third clinic came into play later as an expanded possibility of variation on the initial pattern. S- San Blas, U- Usera, V- Villaverde are the three neighborhoods in the eastern and southern suburbs of Madrid, where the clinics are located.

What relationships with other service structures in the urban context have been taken into consideration?

“The site is not the place” said Enric Miralles when talking about working on the exact layout of a building on a site. The two words can be synonymous, but have different nuances: place (locus) as a portion of space that satisfies a certain condition (in mathematics, equation). Even though we are used to saying “this building is located on this site”, 3x1 can potentially be placed anywhere. As a building without a place, 3x1 is, therefore,

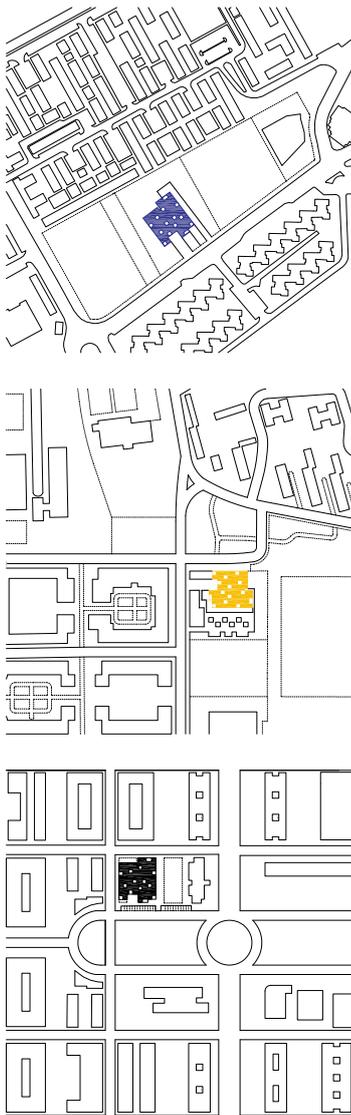


Fig. 2
estudio_entresitio, 3*1, Health care centers in Madrid. Design of the three interventions: SanBlas, Usera, Villaverde.
© estudio_entresitio.



Fig. 3-5
estudio_entresitio, 3*1, Health care centers in Madrid, SanBlas 2005-07; Usera 2005-09; Villaverde 2007-10.
Photo credits: Roland Halbe.

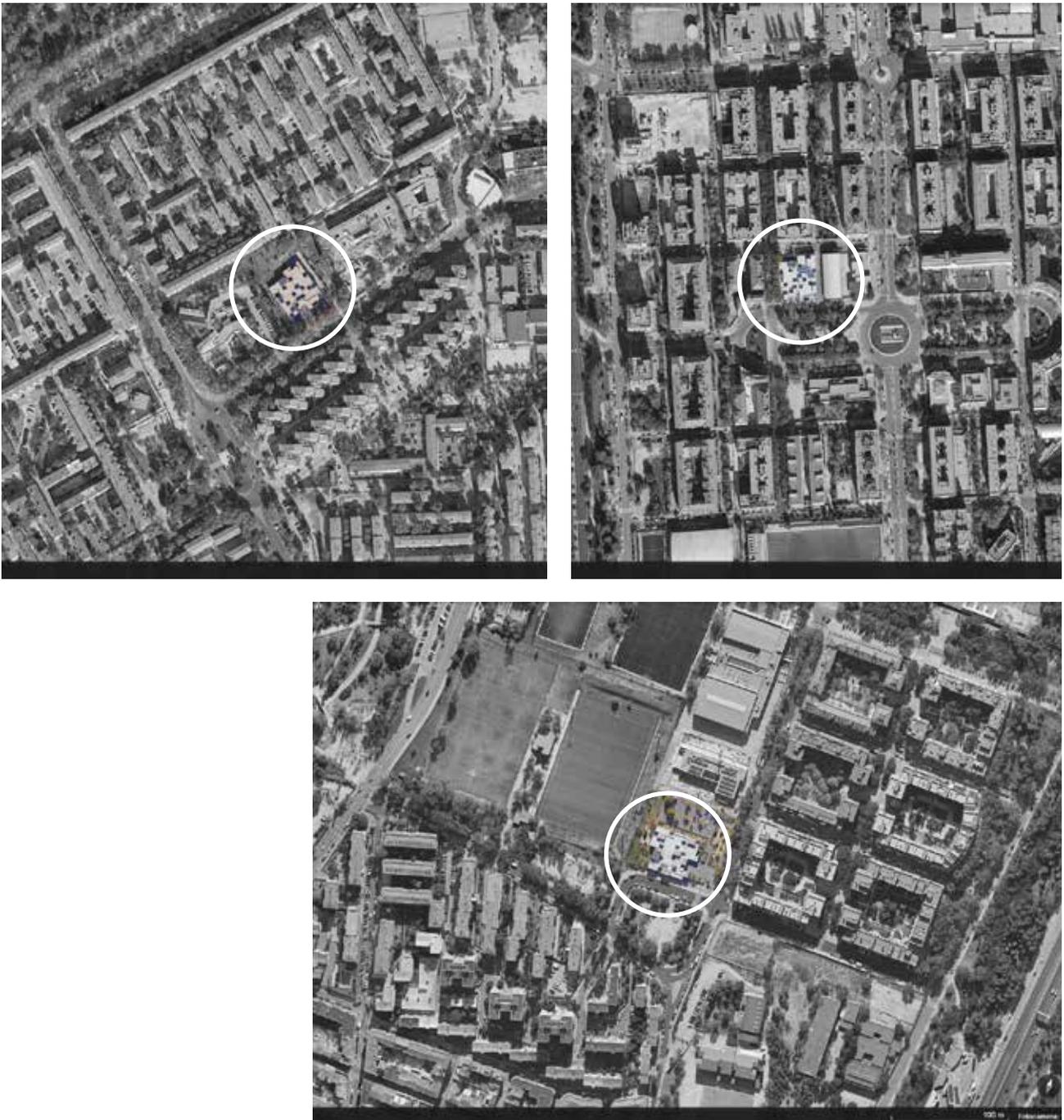


Fig. 6-8

estudio_entresitio, 3*1, Health care centers in Madrid. Zenithal views of the three interventions. SanBlas, Villaverde, Usera. © google maps.

interiority; it is not oriented (the light comes from above). The fact that it receives light from above is the only requirement and the main reason for its autonomy.

Which factors and forms of the urban area in which the project is located influenced the design choices?

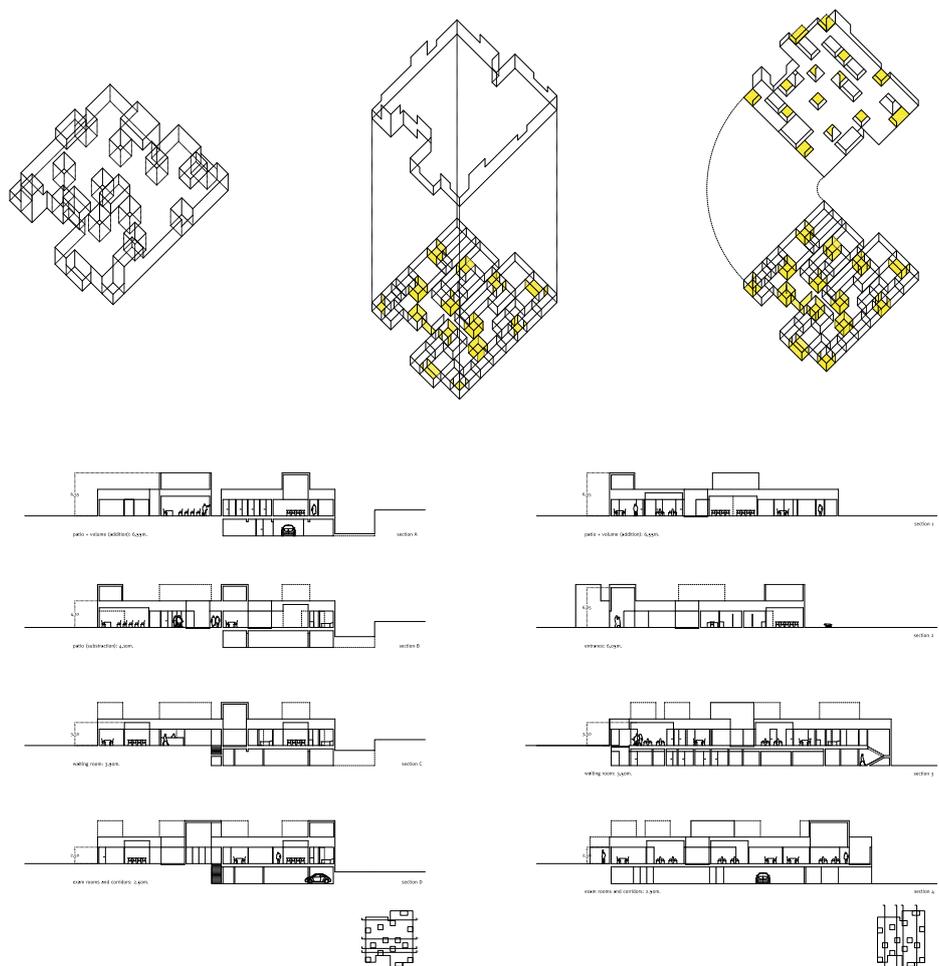
The frontality of the entrance favors the relationship of the built volume with the street, the surrounding social housing complex and its different alignments. However, as an inverse consequence, the roof becomes a real backdrop, a façade exposed to the attention of neighboring buildings.

Were citizens involved during the planning? In what mode?

No, not at all.

Fig. 9-10

estudio_entresitio, 3*1, Health care centers in Madrid: San Blas 2005-07; Usera 2005-09; Villa Verde 2007-10. Axonometries, sections and diagrams.
© estudio_entresitio.



In the planning phase, what was the contribution of health and social workers? (doctors, nurses, social workers, ...).

Madrid Salud, the municipal health department, has many doctors and nurses in its team, including the director of Madrid's health network. They provided the program and followed the development and construction process of the project. These are health centers also with the function of preventive medicine.

What typological and formal criteria were taken into consideration?

The three interventions have the exact same configuration; the program is arranged extensively on a single ground floor in an isotropic arrangement that receives light from above through fourteen patios.

Three main conditions arise from this provision:

- Voids and volumes in the shell.
- The internal public space.
- The perimeter of the outer shell.

In addition to being described as a state of equilibrium between opposing forces, the building can also be seen as a box, but in a very specific way. The roofing plane behaves like a sensitive membrane and effectively becomes the fifth (and only) façade, allowing the building to breathe, where double-height volumes or service rooms emerge that channel light towards the interior.

These volumes (both added and subtracted) are not exactly consequences of formal decisions; they are part of “one of many” possible outcomes of respecting the rules. The rules regarding program and structure (spatial and

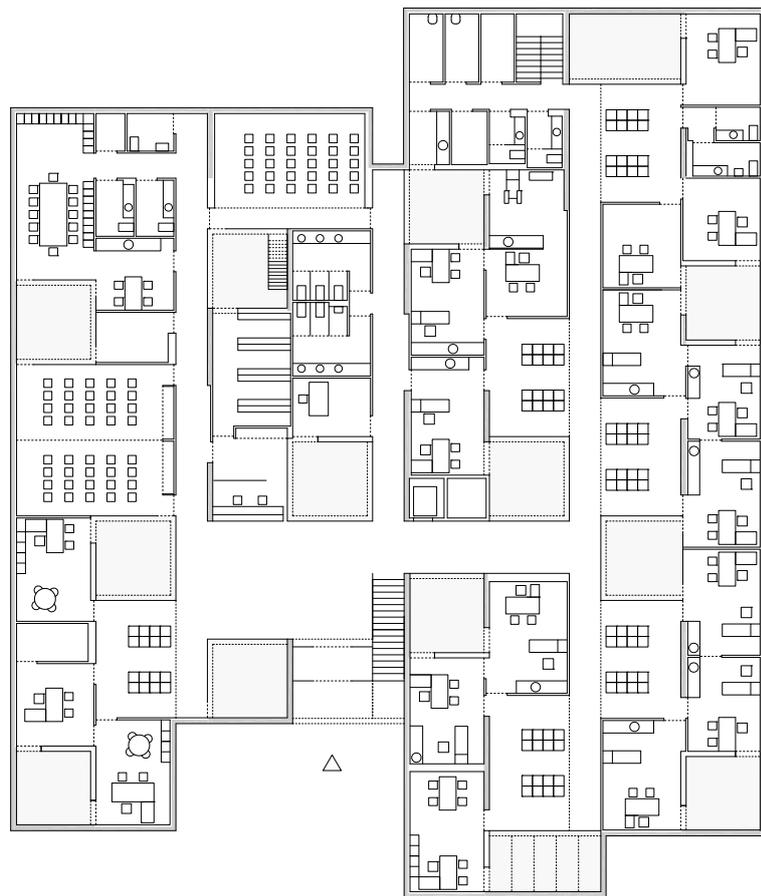


Fig. 11
estudio_entresitio, 3*1, Health care centers in Madrid: SanBlas 2005-07; Plan.
© estudio_entresitio.

load-bearing) provide some 3D surprises that are as welcome as they are unexpected.

What role do functional distribution and connections play in the project?

When the architecture must respond to a complex functional program, we understand that simply responding to the program is not the solution, but the solution undoubtedly begins with the interpretation of the program. From generic understanding to the more specific aspects of each unit, the various parts of the program translate into spatial conditions that incorporate their own system of order with the aim of arriving at a planimetric efficiency that bypasses the most obvious solutions. The rooms (cells), although similar in size and characteristics, have a certain coded information that qualifies the connections between them (doctor-nurse contiguity, entry-exit queue for blood tests, distance of newborns from pregnant women, etc.).

Rules for spatial conditions work at different locations:

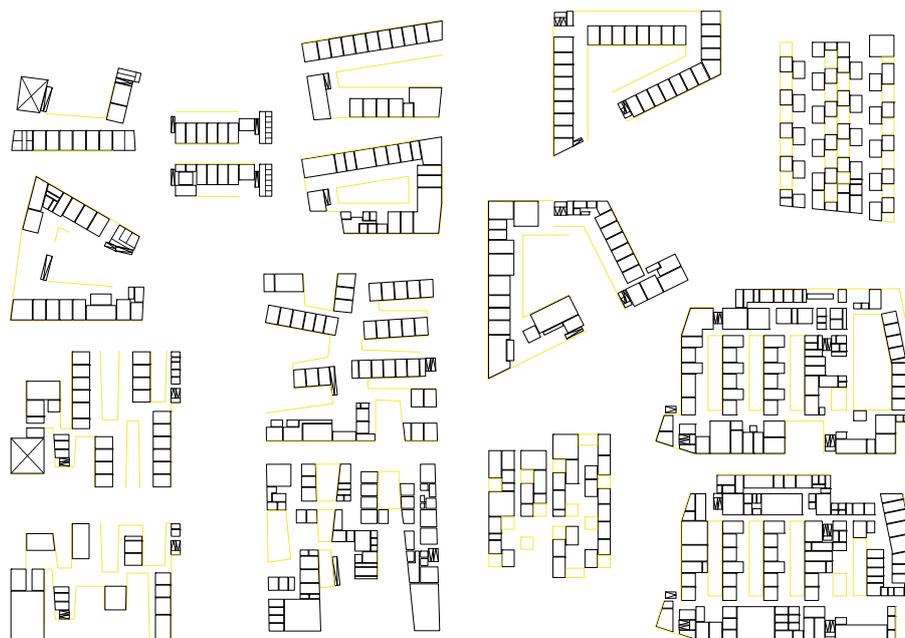
Private public; administrative rooms - exam rooms: two-level layout.

Programmatic bars; offices and teaching - public area - primary care - specialists: “double-double” loading corridors connected transversely.

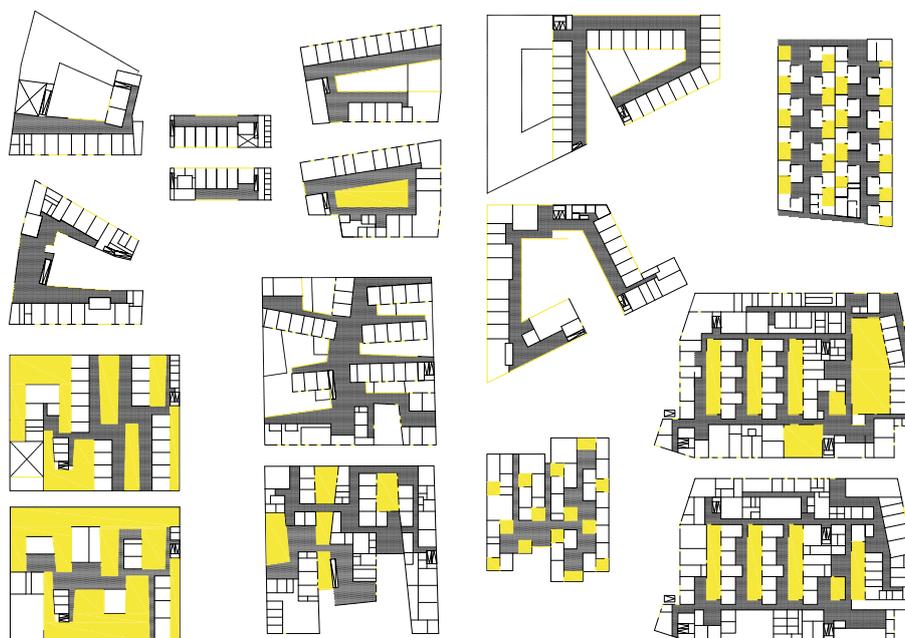
Programmatic specialization (rooms as cells); main programs - support areas - waiting rooms: we can speak of programmatic atomization rather than sectorialization; non-hierarchical atomization.

Does this compositional approach allow you to obtain a good degree of flexibility?

When programmatic bars are placed next to each other to become an extended field and the facade is no longer a binding option for illuminating

**Fig. 12-13**

estudio_entresitio, 3*1, Health care centers in Madrid: SanBlas 2005-07; Usera 2005-09; Villaverde 2007-10. Program bars: rooms and patios (top), patios and public spaces (bottom). © estudio_entresitio.

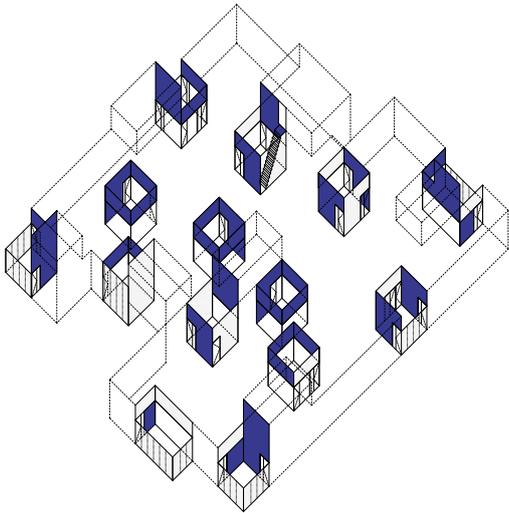


the entire floor plan, new rules apply. “3x1” is a mathematical field condition with a characteristic rhythm that establishes the relationship between order, space and structure. The condition of the mathematical field is linked to the notion of continuity of a given condition (function). The subset that satisfies the continuity condition at all points is called the “continuity field”. Points where the condition is not satisfied are considered discontinuities.

How was the relationship between inside and outside interpreted?

The absence of openings on the vertical walls of the envelope means that the relationship between the interior and exterior of the building takes place vertically, almost with the sky above.

The courtyards bring light into the building and help create a spacious and bright interior, blurring the boundaries between inside and outside, a

**Fig. 14-15**

estudio_entresitio, 3*1, Health care centers in Madrid: SanBlas 2005-07. Axonometry and view of the patios.

© estudio_entresitio.

Photo credits: Roland Halbe.

dissolution of the built limit. The transparency and mirroring qualities of the glass surfaces also create multiple visions, presences and absences, through reflected symmetry.

What do you expect in the future regarding the architecture of health centers?

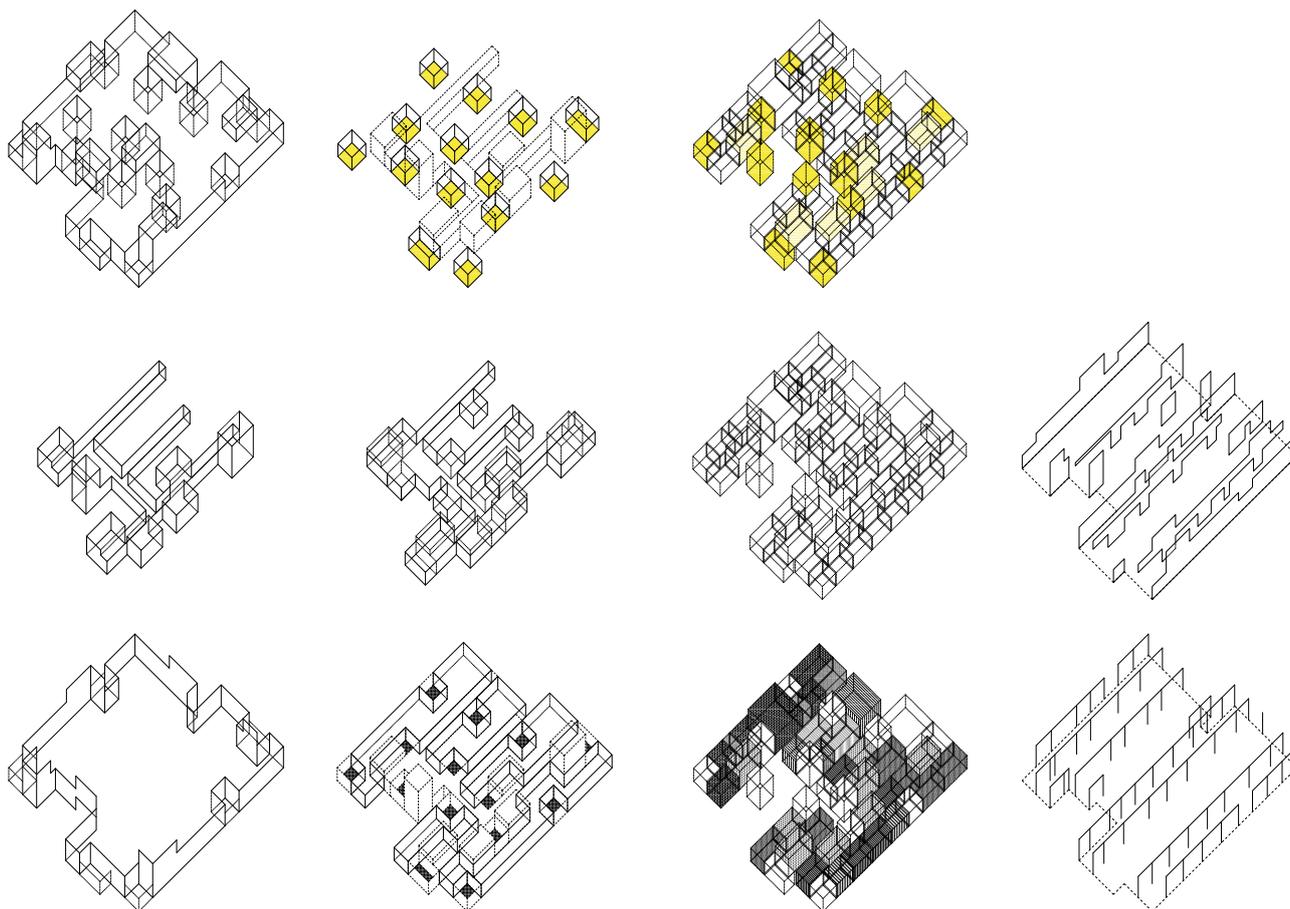
A bright future, I would say. The well-being of patients and how they feel in these spaces is paramount. The operators will do the rest. An example of good practice that we admire is the “Maggie’s” network of British cancer centres.

What are the key factors in designing a healthcare building?

Believing that pragmatism is not at odds with architectural space.

Can design and architecture contribute to patient healing?

Of course, by all means. The power of our minds is incredible. If you are in a healthy environment, it will be easier to feel better.

**Fig. 16**

estudio_entresitio, 3*1, Health care centers in Madrid: SanBlas 2005-07; Usera 2005-09; Villaverde 2007-10. Axonometric schemes: strategies.
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Maria Hurtado de Mendoza Wahrolén and César Jiménez de Tejada Benavides have collaborated since their professional debut in 1993 and both are associate professors of architectural design at ETSAM.

In 2003, José María Hurtado de Mendoza Wahrolén definitively joins the firm after working four years in Rafael Moneo’s firm. Together they founded the “studio entresitio”, a workspace that represents a full stop in their professional career.

Maria and José María were fellows at the Spanish Academy in Rome, while César received his Master of Science in “Advanced Architectural Design” from Columbia University, New York, as a Fulbright scholar.

ASA Studio - Active Social Architecture In the African context: a socio-health facility in Rugerero

Abstract

The interview, edited by Sahar Taheri, concerns the project of the Rugerero Health Center in Rwanda designed by ASA Studio of Kigali through a participatory process that involved local actors. The functional program took into account national health guidelines, local input and architectural considerations. The typological concept favored open spaces, sustainability and integration with the local climate. The design used low-tech materials from the area, involving the community in the construction. The article highlights the positive impact of well-designed healthcare facilities on patient recovery, emphasizing the integration of local context, participatory design and sustainability in healthcare architecture.

Keywords

Health Center — Participation — Piazza

How did you choose the project area?

The place was not chosen by ASA. This project was designed for the Government of Rwanda, specifically for the Rugerero sector in Rubavu District. Local authorities selected the land based on its location, accessibility to a large number of people and proximity to other public facilities (sector office, police station, main asphalt road, etc.).

What relationships with other service structures in the urban context have been taken into consideration?

The Rugerero Health Center is located near a square that houses several other public facilities, including the sector office, the police station (with a temporary prison) and various shops. Furthermore, the main paved road connecting Kigali to Musanze in Gisenyi passes directly in front of the square making it easily accessible. After local authorities chose the land for the Health Centre, ASA conducted a thorough investigation of the area and analyzed the site constraints and potential uses. It turned out that the local community often gathered in the square. The Health Center would also attract community members, especially mothers with young children during vaccination campaigns. With this in mind, ASA decided to create an additional common space in front of the Health Centre, connected to the square but with a dedicated seating area. This project initially included a large avocado tree that existed in the square, which ASA integrated into the design. Unfortunately, however, the local authorities decided to cut down the tree, thus nullifying the effect intended by the design choice. Despite this inconvenience, the square remains an important meeting place for



Fig. 1
ASA Studio, Rugerero Health Center, Ruanda, Africa, 2017. Territorial localization.
© Google maps

both the local community and the patients of the Health Centre, creating a strong connection between the entrance of the facility, the open area of the nutrition block and the existing common space.

Which factors and forms of the urban area in which the project is located influenced the design choices?

The urban fabric surrounding the Rugerero Health Center is dense, but composed mainly of small, one-story buildings. The main mode of travel for the local population, including to and from the health centre, is pedestrian. Some individuals may use bicycles or motorbike taxis, but cars are not used frequently as they are typically only accessible to wealthier individuals.

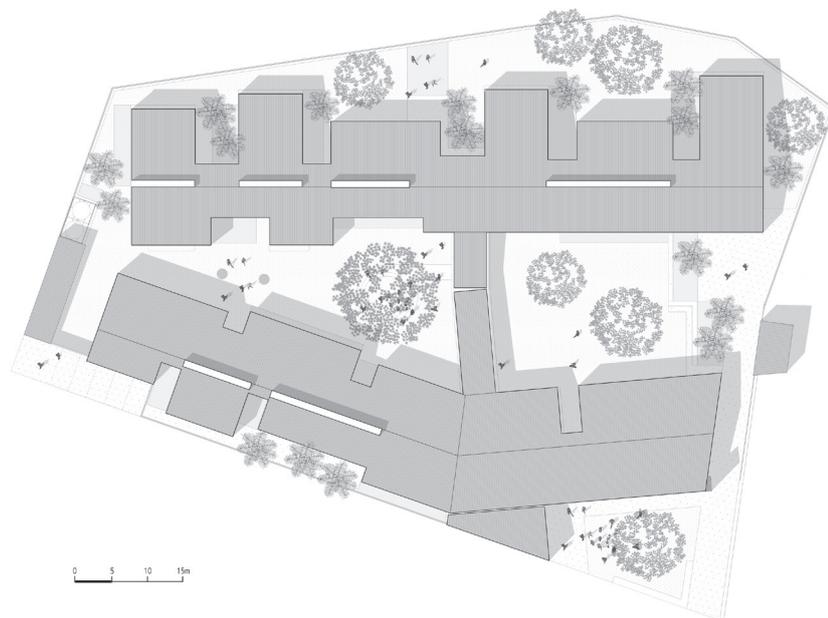
The center consists of a single-storey building with several blocks detached from each other, connected via covered passages. Inside the structure there is only a small car park that can accommodate four cars and, although an access route has been designed for ambulances to reach the maternity ward, it is currently not used.

Were citizens involved during the planning phase? In what mode?

ASA, acronym for Active Social Architecture, firmly believes in the participatory design approach. Therefore, we always involve different local community stakeholders in our design process, including local authorities who train health center nurses and the local community itself. Furthermore, we ensure that a significant number of women are included in both the design and implementation process. In the case of Rugerero HC, ASA used data collected during community-level activities on design, spatial layout and programming preferences to incorporate local cultural heritage into the Health Center planning. Some examples of how our design choices were influenced by citizen input include: the creation of an open communal space where mothers with children can gather for vaccination campaigns and nutritional training courses while having direct visual control over their children; the secondary and more private entrance to the HIV laboratory and consultation room for patients who do not wish to be seen

**Fig. 2-3**

ASA Studio, Rugerero Health Center, Ruanda, Africa, 2017. Roof plan and floor plan.
© ASA Studio



seeking care (due to stigma); the open connection between the blocks that provides clear orientation through the use of colors and the direct visual connection between the blocks; the addition of a pit latrine (traditional toilet) outside the building so that people can use leaves instead of toilet paper (which would clog the toilets located inside the building); finally the design of a water kiosk accessible from the common area where people can refuel with 20 one-litre jerrycans (since most families do not have access to clean water) with collected filtered rainwater, among others, from the roofs of the building.

During the planning phase, what was the contribution of health and social workers? (doctors, nurses, social workers, ...)

Our local partners, an NGO called Health Builders, are made up of doctors, nurses and social workers who focus on training the local community. Their main emphasis is on coaching and mentoring individual health center workers. Instead of training individuals on generally accepted procedures, standards or best practices, their trained healthcare management con-

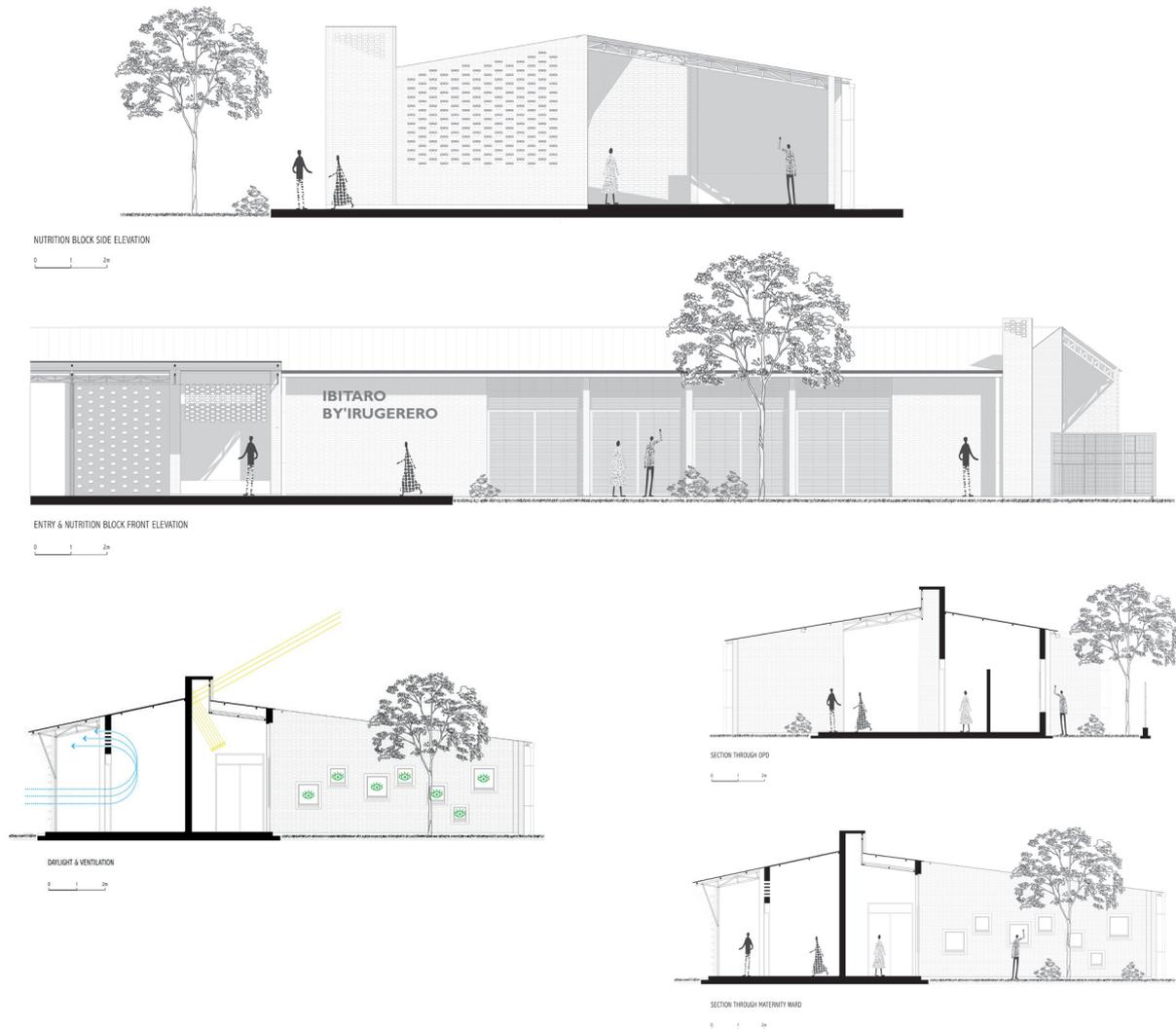


Fig. 4-6
 ASA Studio, Rugerero Health Center, Ruanda, Africa, 2017.
 Elevations and sections.
 © ASA Studio

sultants meet individually with healthcare professionals to address their goals. This process provides ASA with valuable information, design input and feedback that is continually integrated into the architectural product and implementation process.

How was the functional program defined?

The program was based on three main criteria. First, the national guidelines on health center facility requirements outlined by the Rwanda Ministry of Health. Secondly, the inputs received from local authorities and healthcare specialists, who are our partners, on how to make the space more efficient and what additional facilities can be added. These include a separate HIV laboratory, TB isolation room, maternity block design, rainwater filter room, among others. Finally, our design inputs as architects, taking into consideration the local community's way of life. This includes integrating open space, landscape and nature to speed up patient recovery on wards, designing skylights to use natural light to reduce running costs and prevent darkness issues during power cuts, adding of a water kiosk and paintings on the walls of the pediatric departments.

What typological and formal references were taken into consideration?

**Fig. 7-8**

ASA Studio, Rugarero Health Center, Rwanda, Africa, 2017. Internal and external views
© ASA Studio

Throughout the conceptual design process, we considered various typological and formal references to ensure a well-thought-out design. One of the references we considered was the courtyard type, which emphasized the use of open spaces to connect different program areas while maintaining privacy for each space. However, after careful consideration of the specific needs of this project, we opted for a more linear system. Four blocks are connected on two lines and the center is connected via a “promenade” that runs through the place.

What are the reasons and fundamental characteristics of the typological choice of articulation of spaces?

The articulation of the spaces and the typological choice of this project were guided by several key factors. First, ASA prioritized local climate characteristics in the design process. In the northern region of Rwanda the climate is mild and constant throughout the year, with an average temperature of around 20°C. This allowed us to avoid expensive air conditioning and heating systems and adopt a more open design that integrated circulation and waiting areas into sheltered outdoor spaces. Secondly, we aimed to integrate sustainable passive systems into the design. Adequate cross-ventilation was essential to minimize the spread of airborne diseases, particularly in gathering spaces. As a result, we opted for a long, narrow block type that ensures cross-ventilation in all rooms and spaces. Patients circulate in sheltered outdoor areas overlooking the gardens: to minimize direct heat gain through the west facade, we arranged corridors along the west sides as porches, creating a buffer between the interior rooms and the gardens. Finally, it’s worth noting that ASA worked with a limited budget for construction. To keep costs low, we adopted a single-story block system with outdoor air circulation and minimized actual enclosed interior areas. We also used a cost-effective construction technology, with minimal use of reinforced concrete. These design choices ensured that the structure could be built within budget without sacrificing functionality, sustainability or user experience.

What role do the connection, distribution and waiting spaces and the reception areas play in the project?

Connections, distribution, waiting areas and reception spaces are an integral part of the project, facilitating the movement of outpatient patients, patients and staff within the structure. Additionally, these spaces serve as

**Fig. 9-11**

ASA Studio, Rugerero Health Center, Ruanda, Africa, 2017. Internal and external views
© ASA Studio

multipurpose areas where patients can wait, move around, and community members can gather for education and awareness campaigns, depending on the time of day. In the Rugerero HC, space utilization and efficiency are maximized by using larger, multifunctional areas instead of actual corridors to connect the various functional areas, such as consultation rooms, laboratories and departments. These areas serve as reception spaces where patients can register for mutual assistance, undergo triage or be directed to different consultation environments. They also provide spaces for vaccination campaigns, training and movement between different blocks. These spaces are further connected to the surrounding gardens, establishing a strong link between the closed areas of the structure and the natural landscape.

How was the internal-external relationship interpreted?

It is important to note that the natural environment plays a fundamental role in this structure. Green courtyards are strategically positioned between all built bodies to incorporate nature into the complex's environment while providing privacy and open spaces to families and children who visit inpatients or accompany outpatients. The traditional way of living in Rwanda involves spending most of the day outdoors and almost all routine activities take place in outdoor spaces. Our design embraces this practice, making users feel comfortable and "at home" while in a healthcare facility. Finally, the view of the greenery surrounding the buildings is offered to patients in the departments not only to improve their mood but also to speed up the healing process.

What is the solution to achieve spatial flexibility?

There are two solutions underlying the flexibility of the structure. Firstly, common spaces such as waiting areas and connectors have an open-plan layout that can be subdivided with furniture or used as a large collector as needed. Secondly, the modular system can be used for programs so that each space dedicated to a specific function (such as offices) can have a different use in the future if necessary (such as a consultation room).

**Fig. 12-13**

ASA Studio, Rugerero Health Center, Ruanda, Africa, 2017. Internal and external views
© ASA Studio

What role did the choices of language and relationship with the culture of the context have in developing the project?

During the design process we give a lot of value to the heritage of local culture, lifestyle, traditions and beliefs. Our goal is to create a highly contextualized architecture that is efficient in serving users while respecting their culture and promotes a sense of ownership in the community. Our approach is community participatory and we conduct research based on it to develop a project that is accepted and used and which may have a different background than that of the architect.

What technological requirements were taken into consideration in the project? In particular, through which passive technologies suitable for dealing with local climatic conditions?

At ASA, we prioritize the use of local materials and technologies in our projects to minimize construction costs and reduce the carbon footprint from transportation. This approach is reflected in our design for Rugerero HC, where we used low-tech systems that were easy to implement, allowing the local community to participate in the construction process. We used locally sourced materials such as stone foundations and locally fired clay bricks for the walls, as well as a low-tech roof package made up of highly reflective iron sheeting, recycled sound insulation and local pine wood. Additionally, we collaborated with a local cooperative of women who assembled panels of woven eucalyptus branches for screens and door panels.

In addition to reducing construction costs, our design also integrates passive systems that minimize facility management costs and maximize user comfort. We focused on cross ventilation, orientation, use of daylight and mitigation of direct heat gain to guide our design strategy and overall volume layout. We have also installed solar water heaters, rainwater harvesting systems and skylights to reduce energy consumption and promote sustainability.

What are the key factors in the design of a healthcare building, specifically in your intervention context?

The fundamental key factors in designing a healthcare building in the African context are: the provision of improved toilet facilities and the provision of hand washing stations with clean water. These are factors that considerably improve public health and hygiene in areas where access to basic healthcare infrastructure is limited, and it is crucial to include a sanitation facility within the health center premises.

Is there a coherent methodology for tackling this type of project?

There is no single approach to tackling this type of design. However, through years of experience, we have learned how to increase the success of projects in this context. Our approach is to design with the goal of empowering communities, which means that the role of the architect is only a small part of a larger network of interconnected elements, including the community and its leaders, local governments, local partners and their outreach efforts. Our approach is to use our creativity to interpret space from the point of view of end users, while also positioning ourselves as tools for social improvement.

Can design and architecture contribute to the patient's recovery?

Yes, design and architecture can certainly contribute to the healing of patients. In healthcare settings, the physical environment can have a significant impact on a patient's overall well-being and recovery. Studies have shown that well-designed healthcare facilities, especially with integrated elements from the natural environment, can lead to better health outcomes, shorter hospital stays, reduced stress and anxiety, and greater patient satisfaction.

ASA, acronym for Active Social Architecture, represents the international firm's belief and commitment towards the social value of architecture. Based in Kigali, Rwanda, it was founded in 2012 by two European architects and scholars, Tomà Berlanda and Nerea Amorós Elorduy. As of 2021, ASA is operational across East African countries and Europe, with a variety of customers and a wide range of stakeholders. These include organizations such as local and international NGOs, social enterprises, United Nations agencies focused on local and global communities. ASA works in close collaboration with all stakeholders to achieve quality and excellence in architecture and design, focusing on elements that improve people's lives, strengthen and empower communities and their sense of identity. The resulting process is a constant interaction between stakeholder participation, architectural practice and research.

David Kaunitz, Ka Wai Yeung (Kaunitz Yeung architects)
A socio-health center for the Aboriginal population in Newman

Abstract

This article describes a primary health facility located in Newman, a town with a predominantly Aboriginal population about 1200 km from the city of Perth. The first-of-its-kind facility aims to offer culturally appropriate, community-controlled health services, reducing the need for travel to the capital. Located opposite the regional hospital, the Healthcare Center integrates various medical services and adopts sustainable design principles, such as the use of compressed earth and endemic plants. The inclusive approach, inspired by Critical Regionalism, aims to bridge the health gap between Aboriginal and non-Aboriginal people, becoming a symbol of accessibility, cultural sensitivity and community pride in Newman.

Keywords

Healthcare Center — Co-design — Inclusion



Fig. 1

David Kaunitz, Ka Wai Yeung, PAMS healthcare center, Newman, Australia.

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This project is dedicated to the first primary healthcare facility built in Newman (10,000 inhabitants), a town 1200 km north of Perth, the main city of the East Pilbara County (15,000 inhabitants), the size of Japan and with a majority Aboriginal population. A facility that serves the entire county with particular attention to the local Martu and Niabali aborigines. For the first time Aboriginal people will have access to community-controlled and culturally appropriate health services in Newman. The building incorporates the headquarters of the client Puntukurnu Aboriginal Medical Service (PAMS) which serves the remote communities of Kunawaraji, Punmu, Parngurr and Jigalong up to 800km from Newman.

The project site is located across the street from the regional hospital and centrally located in the town of Newman. The Center includes general medical, child/maternal health, dental, therapeutic and other allied health service facilities for specialist doctors visiting from Perth. A key aim was to minimize the significant costs and negative mental health impacts of Martu and Niaboli people leaving their country and family for treatment in Perth. Aboriginal-controlled community health services are important to address major health and social issues that disproportionately affect Aboriginal people. The root cause of these problems is discrimination, loss and destruction of culture and sense of community. Added to this is often the poor provision of infrastructure which does not allow adequate services to be provided, limiting meetings and the arrival of new subjects.

This project is an important component of the strategic plan to expand and strengthen PAMS. Places the community at the center of health delivery while providing additional clinical space focused on acute community health issues. A social health plan focused on community and inclusion with the aim of increasing participation and communication rates to improve

Fig. 2-4

David Kaunitz, Ka Wai Yeung, PAMS healthcare center, Newman, Australia. Schizzi e immagine della piazza.

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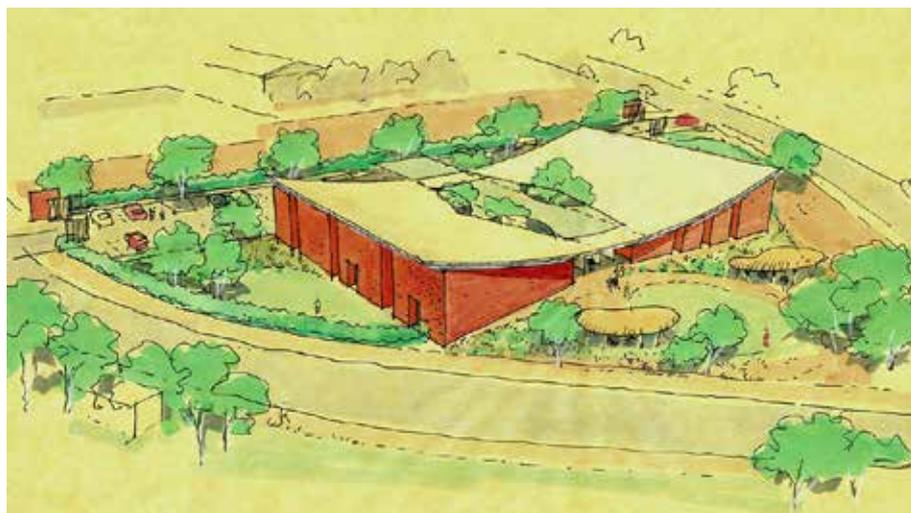




Fig. 5
David Kaunitz, Ka Wai Yeung,
PAMS healthcare center, New-
man, Australia. Location of the
social-health center in an urban
services hub in Newman
© Google maps

preventive health practices. Ultimately, the increase in the rate of medical information is a key parameter for the success of the project. Expanded services and the ability to be treated without traveling to Perth become key aspects. The architectural result also appears decisive. It is necessary to create a cutting-edge structure that is connected to the people, the country and the local culture. In this way it will support high levels of care whilst being imbued with humanity and therefore embraced by the community. A place that the community can be proud of and welcome. A place that puts wellbeing at the center of the community.

The design approach

The architectural identity of the project is imbued with a sense of place, culture and people of the context with the aim of placing wellbeing at the center of the community and physically representing the ethics according to PAMS. This was supported by the co-design process which was an extension of the extensive co-design process conducted by Kaunitz Yeung Architecture during the design of the Punmu & Parnngurr clinics completed in 2018. This was possible due to the fact that the architect has spent a lot of time in communities over the years during projects. Thus facilitating iterative consultation and a true co-design process with the community and specific user groups. Importantly, this allowed for impromptu relationships, under a tree, at the petrol pump or while going shopping and therefore allowing all the voices of a nomadic culture that does not always feel comfortable speaking internally to be heard. of an assembly. The result is a fine-tuning of the architecture that resonates with the community, enriching its characters according to sophisticated forms that correspond to the people, place and culture of the context.

The typology of the courtyard

Courtyard buildings represent a logically based and well-usable architectural type for desert climates. Despite this, this is not a commonly practiced approach in Australia. Courtyards provide a delicate and habitable heart to buildings and this in the most difficult environments. Sheltered from strong winds and sunny spaces, the environment can thrive and people come together. This is fundamental in the conception of this project.

Fig. 6-7

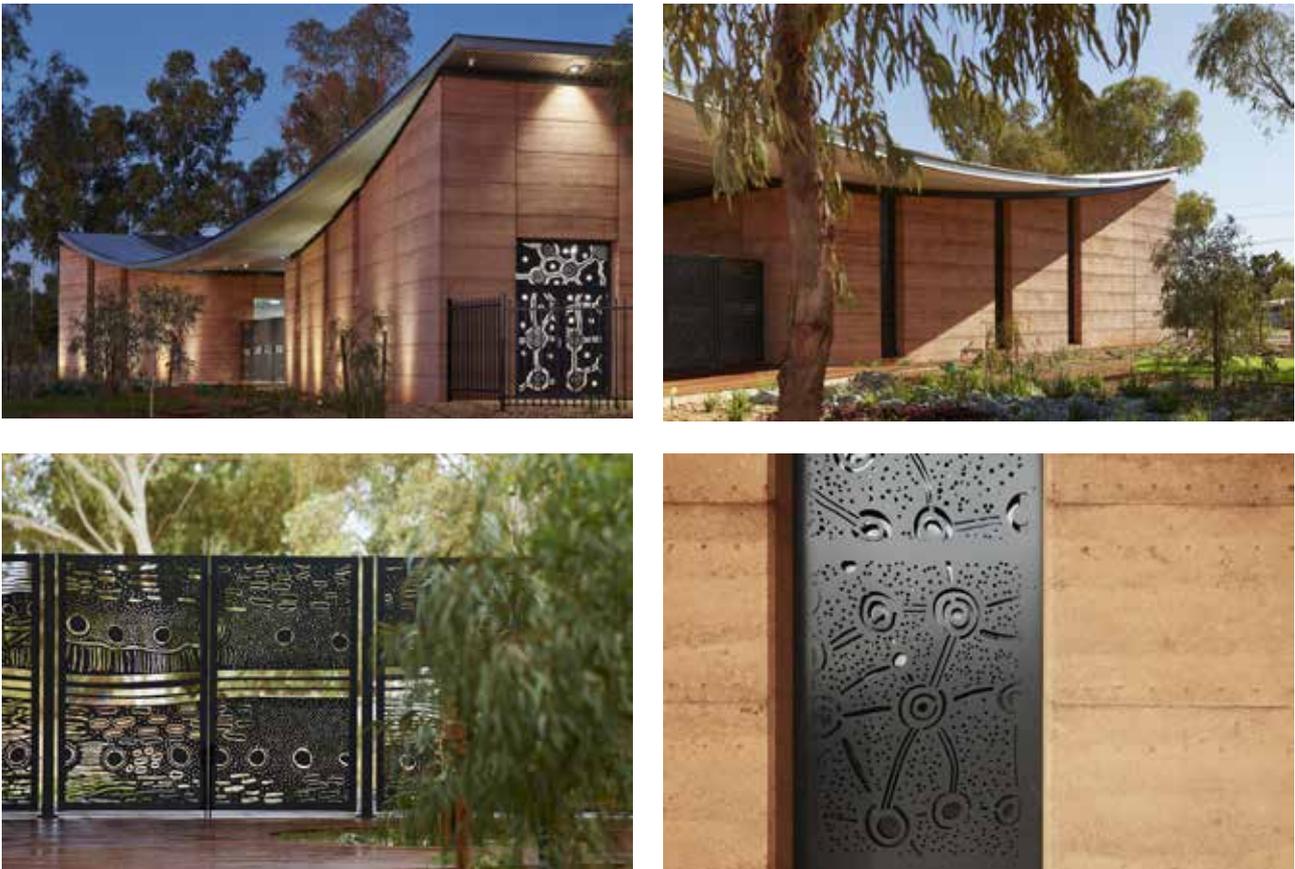
David Kaunitz, Ka Wai Yeung,
PAMS healthcare center, New-
man, Australia. Pianta delle co-
perture e del livello funzionale
© Robert Frith - Acorn Photo



Imagining an Aboriginal-controlled urban space was central to the idea of creating an unfenced public park in front of the building where the local Aboriginal community could feel at ease, determining its evolution as a public space.

The courtyard that serves as an entrance and external waiting area was shaped in response to the climatic conditions of the place and the region. This space constitutes the fulcrum of the project, connecting the car park, the public park, the clinic and the administration. It serves as an outdoor waiting area and provides visibility between clinic and administrative waiting areas to prevent institutional isolation and allow staff to be accessible to the community.

The roof of both built wings slopes towards the courtyard, and is clad in Australian hardwood to minimize the heat sink effect and be comfortable even with bare feet. The downspouts are replaced with spouts that guide the water into the central basin where there is a plantation of mature trees of the *Eucalyptus Vitrix* type, almost as if to imitate the dry river beds so characteristic of the towns of Martu and Niaboli. In the rare rainy events of the year the courtyard is briefly transformed into a pool of water as happens in the surrounding countryside.

**Fig. 8-11**

David Kaunitz, Ka Wai Yeung, PAMS healthcare center, Newman, Australia. Viste.
© Robert Frith - Acorn Photo

Building in rammed earth

Rammed earth is an ancient construction method used throughout much of the world, but best known in places like Mali and Yemen. Earth is an original, abundant, free and sustainable building material. That used for the project came completely from the site, reducing the embodied energy of the building which would otherwise have been clad in prefabricated materials transported from Perth 1,400km away or in concrete.

However, the value of this construction technique goes far beyond that. Rammed earth presupposes a human being in intuitive connection with the place he inhabits. The material is part of the identity of a country. It reflects different light and absorbs rain just like the countryside. This is obvious and immediate for everyone but it is a particularly high and important value for Aboriginal people. Community enthusiasm for the project was palpable once the rammed earth walls were erected well before the project was completed.

This is something Kaunitz Yeung Architecture has learned in previous projects. For the Wanarn Clinic, on the lands of Ngaanyatjarra, a bricklayer from Fremantle worked with the local population in collecting stones to build walls inserted into the landscape and capable of mitigating dust, creating seating and protecting the building from vehicular traffic. The reaction was profound. The combination of the involvement of the inhabitants and the sensitive use of local materials in the project increased the satisfaction with the building among the local population who perceive its connection with the context.

The rammed earth was therefore central to contextualising the project and infusing the architecture with the humanity that resonates with all people, but particularly Aboriginal people.

Landscape and public space

The landscape aspect is an integral part of the idea of contextualising and

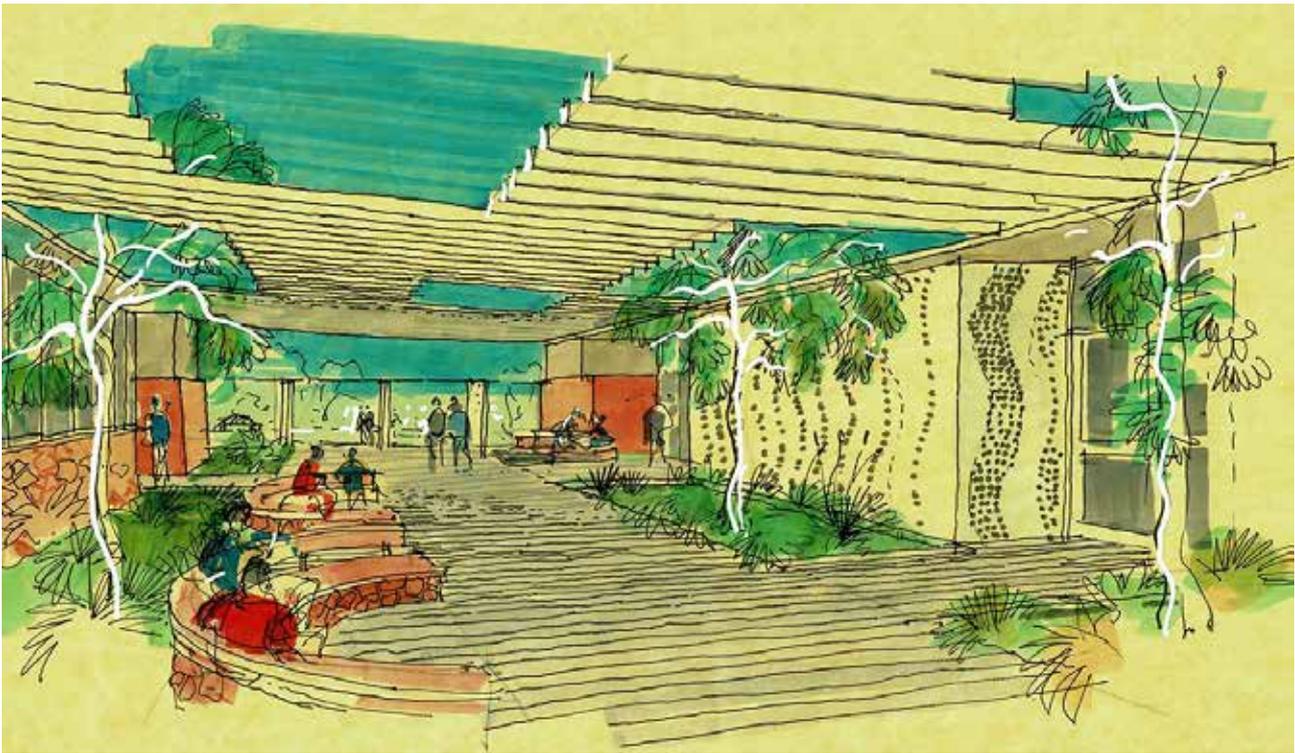


Fig. 12

David Kaunitz, Ka Wai Yeung, PAMS healthcare center, Newman, Australia. Schizzo della piazza.

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connecting the building to the town. Over 2,000 local endemic plants were used to create significant, highly visible and low-maintenance landscape value. Eucalyptus Vitrix were already thriving in and around the site without any care and are the tree species used for the 30 mature trees planted. This more than made up for the 2 trees removed for construction.

The most important thing is the new unfenced public park that has formed in front of the building. This allows waiting outdoors, for example for extended families and children, especially since multiple appointments are normally needed for medical visits. For the first time, a public park owned by an Aboriginal organization has been created in Newman. A rare public place where you can feel at ease and feel a sense of belonging. Over time, community input will be leveraged to further personalize the space and continue to develop a sense of community identity across the park and building.

The landscape of the courtyard is an integral part of the experience one has of the building. The roof has a central opening and the mature trees increasingly shade the space, forming a green environment inside the building. This is the kind of containment and use of nature, rather than oppositional construction, that corresponds to indigenous culture.

Conclusions

In the tradition of critical regionalism, this project determines an innovative architectural structure, deeply rooted in the place and permeated with humanity that generates community identity. This is essential to physically represent the PAMS ethos and increase reporting and participation rates in health programs. In achieving this, the project placed wellbeing at the heart of the community, a key element in efforts to bridge the gap between Aboriginal and non-Aboriginal Australians. This is achieved above all by involving Aboriginal people, empathetically respecting their people, the culture of the place and the country.

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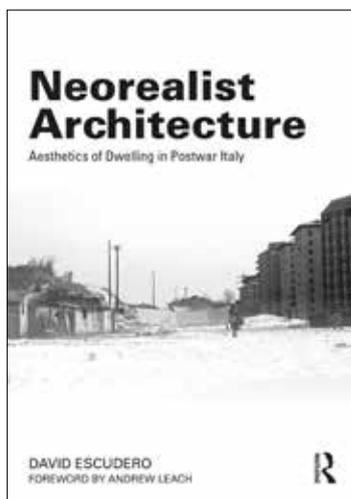
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Kaunitz Yeung Architecture is a multi-award winning internationally recognised practice founded by the husband and wife team of David Kaunitz and Ka Wai Yeung. It combines their extensive commercial experience with David's knowledge of living in and working with communities. The result is architecture that places people at its centre and where good architecture does not need to necessarily be a luxury item. Their projects are bespoke solutions that sensitively respond to clients, stakeholders, end user requirements, site context and the budget.

Damiano Di Mele
Architecture through the cinematographic lens

Author: *David Escudero*
 Title: *Neorealist Architecture*
 Subtitle: *Aesthetics of Dwelling in Postwar Italy*
 Language: *english*
 Publisher: *Routledge, London*
 Characteristics: *17,5x24,5 cm, 222 pages, paperback, b/w*
 ISBN: *978-1-032-23504-2*
 Year: *2023*



Rome, 1947. The cultural climate of the city, which emerges in the pages of the book *Neorealist Architecture*, oscillates between the desolate misery left by the Second World War and the profound desire for the country's social and economic rebirth. These are the main coordinates that circumscribe the perimeter within which the author moves. The book tells of a path (not always linear) that starts from cinema to arrive at architecture through images of the re-construction of the country. It is a path that follows a “free logic” in which the starting point and the arrival point are sometimes reversed. This dialectic offers the reader the possibility of being persuaded, if necessary, by the film's scripts or by the architectural narration.

There are books that narrate in biographical form the intense career of one or more architects, others that specify the shapes and geometries of their design strategies, still others that reveal the hidden face of great works. Finally, there are others, (as in this case), which reconstruct the historical and cultural memory of a now forgotten place. David Escudero, author of the monograph – on which this review is based – is an architect and professor at the Universidad Politécnica de Madrid. Through the pages of the book, he attempts to redefine and expand the boundaries of architectural culture by placing emphasis on its relationship with cinematography. The combination – architecture and cinema – undoubtedly plays an important role among the themes developing in the contemporary architectural debate. By virtue of this, Escudero's book gives the scientific community (and not only) a new possibility of “narration” in architecture. A narrative that seems to move between a film script and rigorous, scientific archive research. He manages to freeze the images and scenes of the selected films by analyzing some architectural episodes. The objective is to ensure that the latter, even unconsciously, are perceived as an integral part of the cultural and intellectual proposal of the film. In this regard, Colin Rowe's considerations on the theme of “narration” come to mind: he underlines, for example, how the story of modern architecture is often more interesting than its products¹.

In the Italian post-war period, the desire for reconstruction begins to manifest itself in various fields of the cultural panorama: in cinema, in architecture, in art and literature. A new current called “Neorealism” appears. In the words of Stefania Parigi:



Fig. 1

Children at the Quartiere INA-Casa in Cesate. Photograph published in «Casabella Continuità», 216 (1957), p. 28.



Fig. 2

Perspective of Piero Maria Lugli's project for the INA-Casa program competition, 1949. Drawing published in Piano incremento occupazione operaia. Suggestimenti, esempi e norme per la progettazione urbanistica: Progetti tipo, vol. 2, Danesi, Roma 1950, p. 13

«Neorealism runs through the history of Italian cinema and culture like a sort of ghost. It is continually evoked both by those who want to destroy its mythology and by those who seek to recover and reactivate it in the dynamics of contemporaneity»².

The term Neorealism, however, has distant origins, which are difficult to ignore in order to understand its deep roots. In this regard, it is necessary to recall the first communicative operations of Italian culture by Massimo Bontempelli who, since the 1920s, tended to mix «always a little bit of heaven with the things of the earth and mystery with the most precise realities»³. Again in 1927, Bontempelli – about twenty years before the exploits of Neorealism – developed an ambitious publishing program (never completed) with the aim of publishing around sixty novels aimed at popularizing a new narrative genre. As Francesco De Nicola recalls: «Bontempelli had identified a new line, that wise mixture of elements oscillating between reality and magic a little later called “magical realism”»⁴. By abandoning those narrative models that tended to ignore everyday normality, we wanted to regain contact with reality, albeit magical. The common goal was to show the face of reality that the regime, also through cinema, was trying to eclipse⁵.

To date, therefore, David Escudero, as an “author” who takes on the role of “director”, uses the camera as a necessary tool to activate a critical and



Fig. 3
Children at the Campo Nomentano, Rome, February 1956. Ph. Italo Insolera. Courtesy by Anna Maria Bozzola Insolera.

interpretative process. He recognizes in cinema that art capable of giving three-dimensionality to architectural works which he has intended to analyze since the beginning of his research. Thanks to the dynamic and reconfiguring power of the camera, Escudero reveals accurate details and cuts out suggestive sequences in movement. Finally, as in a perfect montage, he reassembles the fragments in sequence in the book. As we can see, the images that summarize the meaning of Neorealism are dynamic, narrative, thematic and sometimes even consolatory. It is sometimes difficult to distinguish project images, whether they are photographs or film stills. As Andrew Leach underlines in the preface to the book, Escudero's meticulous research in the post-war years is necessary today «for better or for worse, to put the architecture of that time back in its place»⁶.

The book opens, in perfect neorealist style, with a narration and dialogue taken from the film “L'onorevole Angelina” (1947) set in the Roman village of Pietralata. The author uses this device to introduce the reader to the context and lead him on the journey. The book is orchestrated on three distinct levels which recall autonomous approaches to the theme in which, only in the end, do they tend to align to give rise to a single imaginary. The first part, entitled “Towards a Concept: Neorealist Architecture”, introduces the reader to the birth of the neorealist current and traces the theoretical and methodological foundations on which the case studies stand firmly. In the second chapter “A Neorealist Making in Architecture”, Escudero stages the initiatives that reformulate the place of living, in this case with limited resources. For example, among the case studies, it analyzes the drawings of some projects carried out following the intervention plan of the Italian State (INA-Casa), in force between 1949 and 1963. This “great machine” favors the construction of housing distributed over the entire national territory. The author explores seven architectural episodes, bringing out among others the works of Adalberto Libera, Mario Ridolfi and Ludovico Quaroni. Finally, in the last part “Neorealist Images of Architecture” the individual works are freed from any prejudice and explored through everyday life. In this section, drawings emerge, but above all photographs that portray the places and spaces intended for the community (fig. 1-2). The author sheds light on the theme through a historical narrative – dramatic and comforting at the same time – with the aim of bringing out an ar-

chitectural language that has perhaps now been forgotten. It is a language which, filtered through the cinematic lens: on the one hand tells the needs and current events of a suffering people, on the other it attempts to overcome the profound pain (fig. 3).

Notes

¹ Cfr. Rowe C., *The Architecture of Good Intention*, Academy Edition, London 1994.

² Parigi S., *Neorealismo. Il nuovo cinema del dopoguerra*, Marsilio Editori, Venice 2014.

³ M. Bontempelli, *Superbia*, “’900”, 6 (1928), pp. 1-2.

⁴ F. De Nicola, *Neorealismo*, Editrice Bibliografica, Milan 1996 p. 8.

⁵ Cfr. M. Guerra (edit by), *Invenzioni dal vero. Discorsi sul neorealismo*, Edizioni Diabasis, Parma 2015.

⁶ A. Leach, *Foreword*, in D. Escudero, *Neorealist Architecture. Aesthetics of Dwelling in Postwar Italy*, Routledge, London 2023, p. XII.

Cesare Dallatomasina
The wonder and the concrete utopias of architecture

Author: *Roberto Secchi*
 Afterwords: *Piero Ostilio Rossi*
 Title: *Architettura. Bisogno di sognare*
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 Publisher: *Tab, Rome*
 Serie: *Bauhaus 101. Intercultural Dialogue Books*
 Characteristics: *14x20 cm, 192 pages, paperback, colors*
 ISBN: *978-88-9295-597-4*
 Year: *2022*



The book *Architettura. Bisogno di sognare* by Roberto Secchi is divided into two chapters followed by conclusions, complemented by the afterword written by Piero Ostilio Rossi. After the prologue, emphasizing that the two sections will be united by the concept of concrete utopia, as the author highlights «the need for visions of the future built on a critical, attentive, and radical reading of the present and the projection into projects of profound transformation», the discussion turns to the concept of wonder.

In this paragraph, the meaning of this term in the architectural context throughout the centuries is explored through an analysis of the seven wonders of antiquity and the modern world. It then transitions to its contemporary significance. It is evident that wonder occurs under four fundamental conditions: size/grandiosity (although over time, this has diminished in value due to its widespread nature), technical/technological innovation, symbolic value/communicative capacity, and the beauty of the work and its ornaments (sculptures, decorations, etc.).

These aspects are also addressed in the afterword where Piero Ostilio Rossi points out that «today, in the global world of media, the multitude of works and their dissemination generates disenchantment, and their ability to arouse wonder and surprise is increasingly reduced», and further asks «who still has the strength to be amazed by something in the face of the quantity and pervasiveness of the images that assail us?».

Wonder, understood as amazement, is increasingly difficult to generate today. Both Secchi and Rossi use this aspect to criticize contemporary architecture, which often, in an attempt to evoke wonder, turns into mere advertising, becoming decontextualized, deliberately extravagant, and devoid of content.

This situation leads Secchi to analyze the concept of beauty, which, along with surprise, constitutes wonder, and through Greek mythology, he connects it to natural things. Although the «definition of ‘beautiful’ continues to elude», and linking back to the aesthetic issue mentioned earlier, he adds that what is saved from this decline is poetry. Also in architecture.

For the author, beauty is found in works «devoid of presumption, arrogance, exhibition, rich in humility, which barely reveal the tension of the research that produced them» and capable of enhancing the idea of poverty ; «not understood, of course, as indigence but as a quality that escapes the

materialism of things to assume its spiritual dimension».

What has been stated represents not only a concept of beauty but also the vision of a more communal and solidary world, characterized by radically different lifestyles, oriented towards reducing the superfluous and less focused on consumption. Certainly, these are utopias, but, as suggested by the book's title, it is to them that we must refer, as humanity has done in other historical periods.

In this regard, Secchi, proposing the deliberately antithetical linguistic pair of «concrete utopias», highlights how, only during the 20th century, humanity has been able to carry out several such endeavors. As for individuals, the author traces the visions of Bruno Taut found in his *Die Auflösung der Städte und in die Siedlungen*, Hans Scharoun in his public buildings, Adriano Olivetti in Ivrea, Giovanni Michelucci particularly in his project for the Sollicciano prison, and Ludovico Quaroni and Saverio Muratori in the proposals for the competition for *Le Barene di San Giuliano in Mestre* in 1958. For collective and community production, he describes the INA-Casa plans, the reconstruction of Florence after the 1966 flood, and the initiative in Gibellina following the earthquake. In this sense, he states:

There are many cases of utopias that have marked the future reality of construction. They have the task of paving the way on paths not yet explored; in their abstraction, they cannot, and must not, lead to imitation; articulating principles, revealing the possible not yet become is their task.

However, not all utopias have materialized so clearly; sometimes, they have remained abstract ideas that, due to their unrealizability, have provoked reactions and prompted reflection. Examples are the urban utopias that emerged in the 1970s, formulated by groups such as Archizoom, Andrea Branzi, UFO, Zziggurat, Archigram, Metabolism, Lebbeus, and others.

Secchi's criticism is directed at the present day, as he notes a lack of utopia, the difficulty in imagining a different future, and in dreaming. In this sense, the author examines the period of Neorealism to highlight how, through a reinterpretation of the present, it was possible to "concretize a utopia". This process is particularly evident in some neighborhoods in Matera and Rome, as well as in macro-structural projects like Corviale, Gallaratese, Zen, and others.

What is particularly striking and shared in this text are the criticisms directed at the world in which we live and the situations that have generated it, such as globalization, environmental and social issues, the current economic and development model, and more. However, there are also optimistic conclusions regarding the possibility of a better future, based on the observation of positive realities around us. The author emphasizes associations, volunteering, youth movements, non-profit agencies, and others that reflect the wonder of the present and the concrete utopias of the future.

Carlo Quintelli
Rome and the difficult task of being the capital

Editors: *Andrea Bruschi and Paola Veronica Dell'Aira*

Title: *Roma città delle istituzioni.*

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Every university architecture department should be able to have books like this at their disposal to offer to student-architects who experience the city and the university at the same time, and who make the host city the first preparatory factor, the natural field of applied cognitive and design exercise. In this case the volume *Roma city of institutions, Urban strategies, plans, projects* (*Roma città delle istituzioni. Strategie urbane, piani, progetti*) edited by Andrea Bruschi and Paola Veronica Dell'Aira, Quodlibet 2022, on the release date “the last of twenty books dedicated by professors of the Department of Architecture and Design of SAPIENZA”, effectively transmits, through documentary analysis and argumentation, the meaning of the relationship between architecture and the city, between history and the phenomenology of urban becoming to which the project is called upon to contribute in the contemporaneity of having to prefigure as well as doing. The city is Rome, capital city of the State even if the title leaves this attribute implicit, already alluding to its difficult if not unresolved reification. Of course, if we look carefully at the complexity of the events carefully reconstructed and the feeling of frustration that often emerges in the various essays due to missed opportunities, one would think that the type of the capital city of a nation even before that of a state can be done with ease of intent only when we start from the blank slate, not only physical but also ideological-semantic, what Jefferson identifies as no one’s place and therefore belonging to all those who contribute to the birth of a nation. Only with those assumptions will a clear perspective appear to Pierre Charles L’Enfant and subsequent architects, and with the incipit of the Jeffersonian sketch, to design the city of Washington, the capital par excellence of the modern era, with structural and image coherence. Which also happens, although with greater difficulty, in the old cities of Europe, from Paris to London, from Madrid to St. Petersburg and then to Moscow, since they matured at most in five or six hundred years and therefore not entirely resistant to those processes of formal as well as functional restructuring of a re-foundation nature which imposes the capital role. But in the case of Rome, unique in the world, we have well over two thousand years of urban construction and, as Luca Porqueddu carefully reconstructs in his essay, the dense historical palimpsest of form and matter that characterizes it, starting from the radiocentric incipit of the origin, is very little open to

the uprooting imposed by new urban design logics which consequently, between the nineteenth and twentieth centuries, substantially confirm the centripetal densification of the ancient capital reiterated in the Caesaropapist one.

From here arise alternating considerations between renewed prefigurative impulses and the futility of efforts. Those of which Alessandra Capuano is aware when, in the presentation, she quotes a Ludovico Quaroni who with ironic fatalism speaks of “a possible sudden outburst which however has always been avoided, for centuries”, thus shifting the attention to the concreteness of liveability, of greenery, of archaeology, that is, of the right to be a city even before being a capital city.

On the other hand, the meticulous historical excursus on the role of the ministries in the development of Rome as a capital developed by Piero Ostilio Rossi, the dystonias in the relationship with the pre-existence told by Gian Paola Spirito in the first phase of the Risorgimento, with the support of an eloquent localization mapping created by Francesca Romana Castelli and Giovanni Rocco Cellini show a dramaturgy of interrupted, partial, occasional transformation, with great architecture that is as rhetorical as it is incapable of breaking the enveloping canvas of millennial Rome.

Paola Veronica Dell’Aira reminds us of this well also with respect to the second re-founding opportunity, that of fascist Rome, which was also incapable, beyond the imperial narrative, of determining an alternative structural design.

In a very different political and cultural context, the same attempt by the SDO in the 1960s, starting from the Pietralata district and the Tiburtina station according to an equipped alternative route to the radiocentric system, remained largely unimplemented and marked the retreat in the 1980s towards a plan of crown centrality, because in the meantime the city has expanded like wildfire and a single strong direction of polarization of the capital’s facilities no longer seems to hold, or perhaps does not respond to a broader and more distributed articulation of real estate expectations. There remain calls from many architects including Samonà, Portoghesi, Purini, Tange and many others but the design of a capital to be built definitively loses consistency, remaining the prevailing theme of a metropolis whose expansion has in the meantime accumulated significant delays in terms of formal, functional and infrastructure structure. It is no coincidence that Andrea Bruschi rightly allows himself to underline “the price of the short-sightedness, indolence and bad faith of those who governed this city” which however, to be honest, seems generally refractory to any attempt at coherent and incisive urban transformation policy. In short, the problem lies equally in the history of the civitas and the polis.

Thanks to the reform of Title V of the Constitution which drains directionality of the State established in the capital in favor of the Regions, Bruschi and others seem to definitively take note of a long phase of unimplemented attempts starting from the Unification of Italy, thus looking towards a decisive change of focusing on objectives and interpretative register, according to a project epistemology extended to other disciplines such as environmental sciences, sociology and urban psychology. This is what emerges from the Anello Verde project “between the railway system, environmental structure and regeneration based on the criteria of the liveability of the urban space without giving up elements of settlement strength of public interest, for research and culture” and of the eastern pole with particular reference at the Tiburtina – Pietralata node where the design demonstration,

supported by applied elaborations of the doctoral school in Architecture, Theories and Project and by degree theses, enters into the concreteness of the possible ambitions, without however falling into certain defeatist practices of “mending” rather than pseudo -environmental ones of “urban jungle”, rather through an architecture still aware of making, if not a capital, a real city.

However, this change in perspective will not prevent Rome, as Dell’Aira suggests, from interpreting the meaning of capital in a universal sense as in the case of Walter Tocci’s proposal for a Mediterranean Capital through a Permanent Euro-Mediterranean Forum (FERO) based on values, today more necessary than ever, bearers of “dialogue, diplomacy, interculture, solidarity”. A very different rhetoric, but no less important, of being capital.

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Architettura che cura il pianeta

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The third publication of the series «Architettura Sostenibile. Estetica risorse riuso» focuses on sustainability not only in technical and technological terms but also from a humanistic point of view, culturally closer to the field of architectural design. The title of the volume is inspired by the 1970s Debord's well-known essay *La planète malade* and so investigate architecture as a “therapy”, or as a discipline that should be not an expression of a sick society but again, as it was in the past, of the fine balance between development and progress on one side and sustainability and care for the environment on the other, thus resolving this dialectical relationship through the culture of design. The essay takes its roots in the origins of environmentalist movement born between the 60s and 70s to go even deeper into some fundamental cultural references of the relationship between society, development and environment, namely American Transcendentalism and the Frankfurt School. Of the former the author demonstrates how some themes born in the artistic and literary field with Emerson, Whitman, Thoreau then nourished a certain architectural culture that had wide resonance in the last century; about the latter then, starting from Adorno and Horkheimer's Dialectic of Enlightenment, it is explained how the critique of the exploitation of the environment operated by a “sick” capitalist society has subtly animated the research of figures such as Soleri or the Japanese Metabolists. What emerges is a tangible permanence of the sustainability within the founding core of an architectural episteme that can respond, as it has always done in the past, to this complex challenge as a “space therapy”. A concept that has already been introduced by Plato in *The Republic*, first of all starting from the city seen as a to-be-cared-pasture that is necessary to feed the community's well-being.

Is architecture still committed to profitably fulfilling its fundamental therapeutic purpose today? Is it still the means by which people take care of its environment and therefore of the society of which it is the expression? Instead, everything would seem to point in the opposite direction and it is easy to see how the climate change has not been matched by an analogous architectural change. With the eye of a cultured designer Sbacchi makes a deeply reading in the reasons of this lack of alignment and of the resulting crisis of disciplinary identity, as an incapacity to intimately see the *transition* not only pragmatically through its tangible manifestations but also as the result of a process of cultural involution in our relationship with science and technique, as Husserl have well explained.

Important themes that the author clearly describes, with examples at the small and large scale of architecture and landscape, dealing with little-known episodes or rediscovering them in the light of new challenges such as the environmental one and always showing a motivated originality as only those who well know the topics can do. The subjects are various, the new meanings and expressions of living and domesticity, some innovative but not sufficiently valued experiences of the last century, the use of territories for a new vision of the landscape. Areas of research that are sealed together through a mature reading of architectural design also in the light of the principles of philosophical hermeneutics and of phenomenological and existentialist thought. It therefore seems to us not obvious to agree with the author that architecture can continue to play a role only through a conscious recovery of its cultural depth. The heritage outlined by Husserl and then developed by giants such as Heidegger and Merleau-Ponty is in fact the same which, through a long series of references, then comes to nourish the tradition of studies such as that of Rykwert, Vesely and Perez-Gomez. Scholars that the author had directly known and that nourish a critique of the current drift towards an anti-humanist desemanticization built only on quantitative and not qualitative parameters. Drift well summarized by the 1950s Adorno's "impossibility of dwelling", that is, the loss of meaning of the notion of domesticity. A theme that obviously concerns not only the house but all architecture in general, as a link between the world, the system of objects, and our bodies.

Behind the easy branding of words such as "borgo" or "resilience" is often hidden a plethora of concepts without a real cultural depth. Where to look then? The heritage of micro-settlements of the Sicilian rural hinterland is perhaps the most evident example of a possible backdoor to find new ways for the urban agglomeration through design. Open-air archives of a constructive knowledge that is above all sharing a common cultural vision that binds community and environmental continuity and that brings out important concepts such as *contamination* or *contextual specificity*. These concepts help us to fight the uncritical hegemony of globalization that erases the value of places in favor of technological dominance and standardization.

The author uses history as an operational knowledge, a language in continuous transformation where the concept of *metamorphosis* emerges as an essential quality of innovative architectural organisms that demonstrate a possible harmony of modern and vernacular. The importance of both conceptual and operational categories such as *soil* and *void* in the definition of new relationships between landscape and city (Secchi, Koolhaas, Corner) shows the possibility of always finding connections with widely settled disciplinary issues (Laugier, Milizia, Tafuri, Corbu). Among the many topics addressed, the countryside-architecture relationship seen in the landscape's construction is very interesting. Particularly, where the building becomes contextual to the agricultural production system highlighting the rules that governs the territory to bring together fields (built architecture and cultivated countryside) that important studies such as those of Pagano and Sereni have deeply investigated each for their own areas without however arriving at a unitary vision.

Another side of the coin, even more unusual in our reflections, is that given by the so-called *energy landscapes*, the "cultivation" of the territory for the production of renewable energy resources, solar and wind power. Same issue for infrastructures, which are addressed with little-known examples such as the Morandi viaduct in Agrigento. Agriculture, architecture, infrastructure, energy production systems, all areas that must enter into a new homogeneous and structured vision of the landscape as a "logical con-

struction". Given that the architecture of the future will increasingly be the transformation of the existing, the theme of its hermeneutical reading becomes even more central, strategic for the interpretation and governance of this metamorphosis.

Ultimately, in addition to the very fresh, serene writing devoid of unnecessary complications as in so much specialized literature, to the very rare and very brief notes, to the original and not obvious bibliography, what appears cogent among the characteristics of this volume is the ability of its author to create short circuits between disciplinary fields usually not inclined to dialogue. The essay makes concretely tangible themes and experiences even very far from our daily practice and at the same time elevates facts and examples that generally fail to evade from areas of local culture or specialisms to the rank of scientific matter. The author shows an ability that is generally more noticeable as a quality of relating in figures more dedicated to concrete application in design. Thus, as in a design process, different subjects, heterogeneous in terms of characteristics and temporality coexist in the essay in a meaningful unity, as all equally contemporary. An aptitude, marked by *sprezzatura*, capable of accommodating all the complexity of reality, the most representative example of which is perhaps precisely that adopted by Scarpa in Sicily in the refurbishment of 'u Cubu, the Palazzo Steri in Palermo.

Note di chiusura