
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.

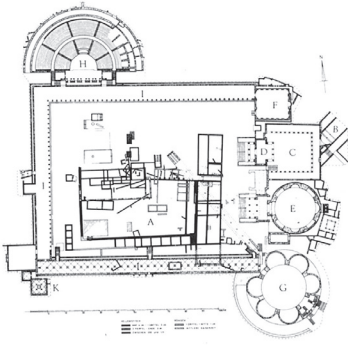
Keywords

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

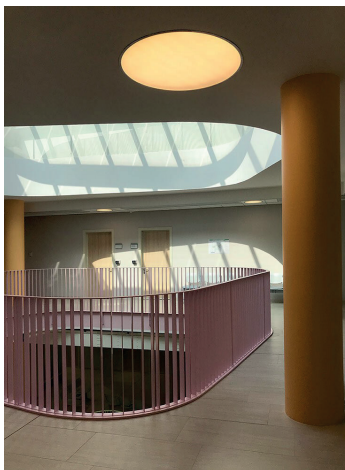
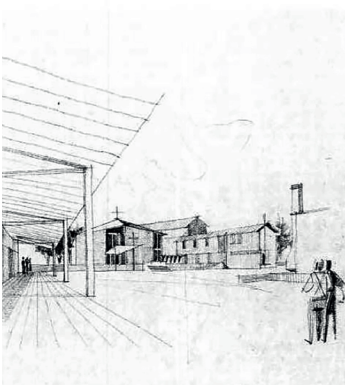
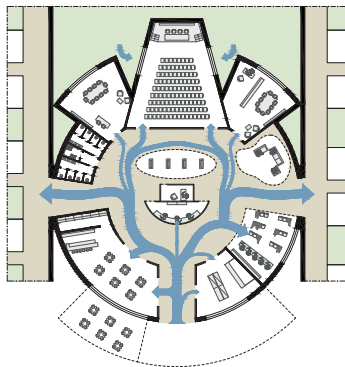
If we then want to understand the general delay in terms of awareness, interpretation and research in the architectural case for the structures once defined as *Health Houses*, we must consider that the issue, in a strictly healthcare sense, arises only within the National Health Plan 2006-2008 (Presidential 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 (FA-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-

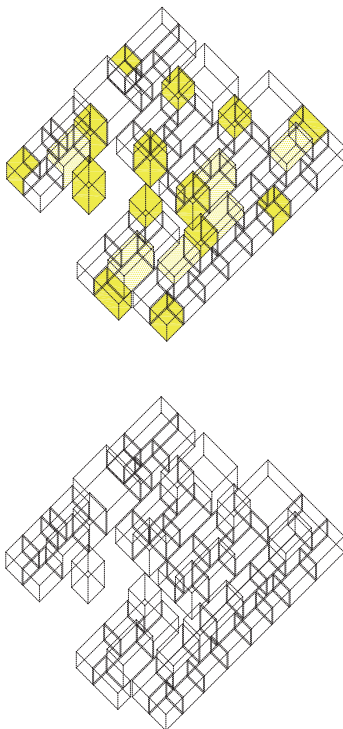




tieth century, where the modeling of the hospital structure seems to be compared between the efficient and self-referential hypothesis of Henry Ford and that physiologically related to the demands of the urban society of the *Cité Industrielle* according to Tony Garnier. The latter is a reference which 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, *Casa 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 homes 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.