

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.

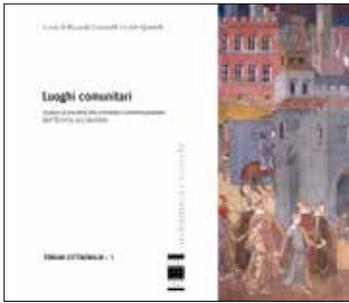
Keywords

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

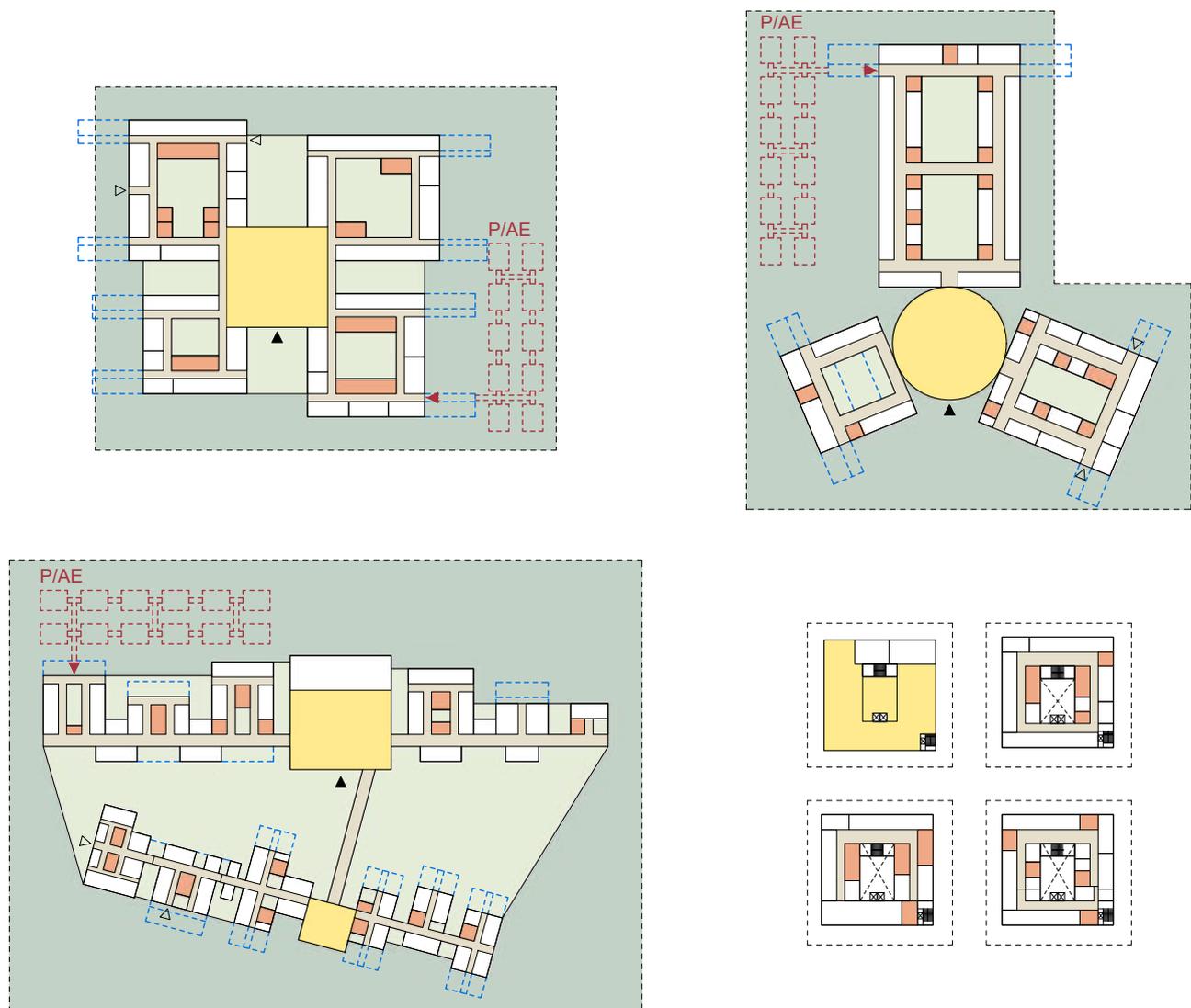
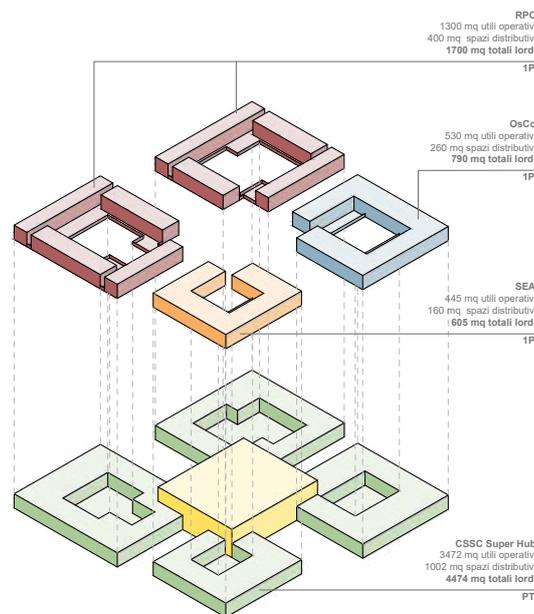


Fig. 4
 Typological studies for the superHub model:
 Specialized court typology
 Radial type
 Open aggregate type
 Multilevel typology
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through which abandoned and convertible areas or structures in the urban fabric are often identified when it is planned 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.

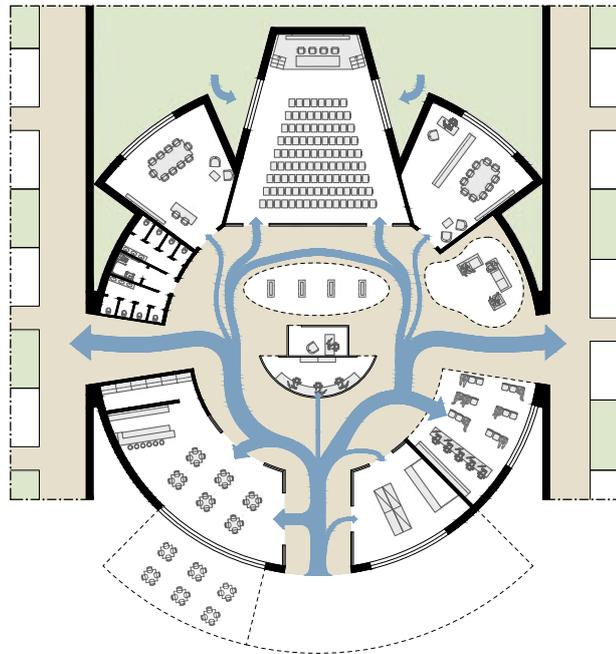


Fig. 6
Reception area for the SuperHub model.
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With respect to what we can define as the architectural scale of the project, the research focuses on the typo-morphological device, involving both the internal, closed, covered and open-air spaces, and 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

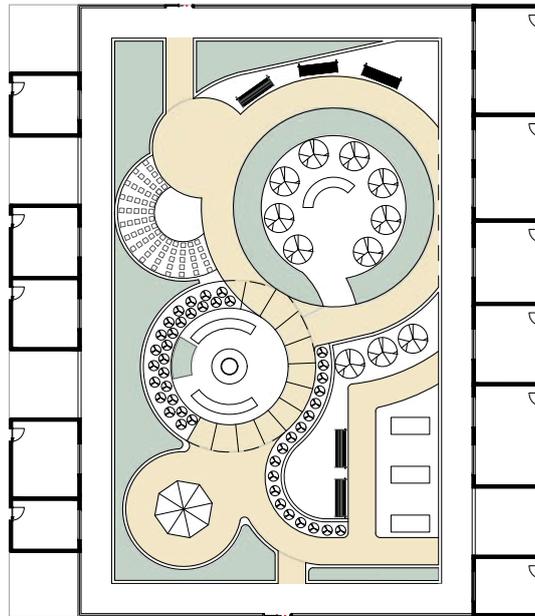


Fig. 9
Healing garden study for the superHub model.
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the fundamental task of interpreting a community reality that combines with the healthcare one, with the need to open the building to the life of a city that finds itself there not only for care needs 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

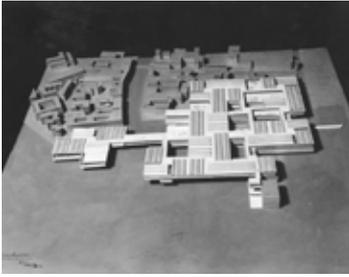


Fig. 10
Le Corbusier, Project for the Venice Hospital, 1964.

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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