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Adapted Physical Activity for Elderly People and National Policies. A Comparative Investigation

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ABSTRACT

The global demographic transition presents challenges and opportunities for Western societies, affecting biological, psychological, and social aspects. Ageing is linked to a decline in physical abilities, worsened by sedentary lifestyles, which reduce autonomy and quality of life. Public policies must promote "active ageing," with APA as a key tool to address ageing-related issues. This study examines APA policies in Italy, France, and Belgium, three European countries significantly impacted by demographic changes. Italy's fragmented approach reflects regional autonomy; France has institutionalised APA in preventive health; Belgium's regional innovation is hindered by a lack of national coherence. The paper emphasises the need for a holistic integration of sociological, psychological, and institutional approaches to support active ageing effectively. It calls for a shift from traditional biomedical models to more inclusive frameworks that respect older adults' autonomy and dignity, offering valuable insights for shaping future strategies to address an ageing population's evolving needs.

1 | Introduction

The global demographic transition is characterised by the ageing of populations, evolving from a high mortality and high fertility regime to a low mortality and low fertility regime, primarily impacting western societies (Bongaarts 2009; England and Azzopardi-Muscat 2017). This demographic transformation is anticipated to intensify, with the share of individuals aged 65 and older projected to double worldwide by 2050 (WHO 2020). Addressing this phenomenon necessitates a comprehensive bio-psycho-social perspective (Kanning and Schlicht 2008).

Biologically, ageing brings about anatomical and functional changes that affect individuals' capacity to lead autonomous and fulfilling lives (Greco et al. 2019). This leads to a cycle of fragility, marked by indicators such as reduced muscle strength, sarcopenia, diminished lung capacity, balance loss, and overall decline in physical performance (Scott-Warren and Maguire 2017).

Psychosocially, sedentary lifestyles often escalate with age, exacerbating potential health issues and diminishing autonomy, creating a challenging cycle to break (Harvey et al. 2015).

From a social perspective, public policymakers must grapple with the health and social implications of an ageing population, including access to services and the economic sustainability of care and self-sufficiency. These challenges are intricately tied to the concept of "active ageing" and the role of older individuals in society (Walker 2002; Esposito et al. 2023).

Responding to these dynamics involves a transformative shift in habits and lifestyles, particularly through physical activity (PA).

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PA proves to be a valuable tool in managing the multifaceted aspects of ageing, as, for example, well-being, quality of life, and active ageing. These represent a multidimensional concept that includes aspects related to individuals' functional capacity and mental health. For older adults, the definition of quality of life is similar to that for other age groups, but physical and mental abilities are much more susceptible to decline. However, previous studies indicate that normal healthy ageing is not a disease but is often linked to cognitive and functional deterioration (Bacanoiu and Danoiu 2022).

In recent decades, PA has been closely associated with the active ageing paradigm, where staying youthful and healthy is achieved through physical effort. International guidelines now emphasise regular PA as a cornerstone of healthy ageing and disease prevention (Beard et al. 2016). PA becomes a prescriptive activity, recommended if not enforced, for all ageing individuals (American College of Sports Medicine 2009; Stenner et al. 2011; Tokumitsu and Barkley 2023).

A crucial aspect of this approach is Adapted Physical Activity (APA), a cross-disciplinary field aimed at addressing impairments, activity limitations, and participation restrictions. APA encompasses various domains, including physical education, sport, recreation, dance, creative arts, nutrition, medicine, and rehabilitation (IFAPA—International Federation of Adapted Physical Activity). Discussions about APA involve specific professional profiles with extensive academic training, emphasising support for individuals bearing elements of fragility. All forms of APA are designed to enable individuals with limitations to access an active lifestyle through participation in PA.

For example, it has been demonstrated that individuals with dementia can also gain from different exercise routines to enhance overall cognitive function, particularly during the early to moderate stages of the disease. Moreover, physical activity can enhance balance and decrease the likelihood of falls (de Rondão et al. 2023).

Against this backdrop, our paper delves into the critical role APA plays in conditioning the quality of life for older adults. We specifically explore and compare APA public policies and legal frameworks in three neighbouring European countries—Italy, France, and Belgium—that are particularly affected by the demographic transition, offering strategies to foster active ageing.

2 | Notes About Italian, French and Belgian Systems and APAs

2.1 | Examining APA'S Policies and Legal Frameworks

According to the definition developed by the WHO in the early 2000s, a health system encompasses activities aimed at promoting, restoring, or maintaining the health conditions of beneficiaries. This formal characteristic applies to national health systems and their specific mission to influence "non-health" systems, which are institutional frameworks designed to protect citizens against the financial costs of illness, ensure their dignity, and implement prevention plans. In a circular logic, a state's health system adopts the specific characteristics of the historical, socio-economic, and cultural context in which it operates.

Europe, due to its rich history and cultural diversity, provides a fertile ground for anyone with comparative aspirations. Comparative analysis attempts to "simplify" an extremely complex reality by labelling approaches, analysing performances, and offering effective interpretative tools.

The strong administrative decentralisation that has characterised the Italian system in recent years has led to a reallocation of a significant portion of competencies outside the strictly state domain, in accordance with the principle of subsidiarity. Regions possess residual legislative authority (comparable to that of the state) and intervene in all areas for which the state is not expressly responsible. However, administrative functions remain in the hands of municipalities (Article 118 of the Constitution). Following the reform of Title V, the Italian Constitution also recognises a high degree of financial autonomy for municipalities, provinces, and metropolitan areas. This autonomy is considered by doctrine to be "regulatory" in nature, not equivalent to that of the regions and, in any case, stemming from regional legislative competence.

The organization of the French state is structured into four levels: national, regional, departmental, and communal, all rooted in the Napoleonic model, similar to Italy. Since the 1980s, decentralisation in France, particularly in social policies, has led to the creation of significant intercommunal entities. The French social protection system, initially based on the Bismarckian insurance model, is now hybridised, resting on two pillars: social security and social assistance. Social security covers retirement, health, family, and employment, accounting for 90% of social protection expenditures. Social assistance, based on vulnerability, includes social aid (legal benefits provided by departments) and social action (optional interventions by municipalities). Despite decentralisation, centralisation of resources and national regulations limit local autonomy, fragmenting the insurance-based social protection system.

In Belgium, recent initiatives in APAs have emerged outside any legal framework, inspired by the French model where APA is institutionalised and recognised as a non-pharmacological therapeutic tool. These locally-driven treatments, situated between prevention and cure, are now available in four Walloon municipalities: Chaudfontaine, Frasnes-Lez-Anvaing, Ottignies, and Saint-Hubert. This opportunity is facilitated by local non-profit organisations and various co-financing sources. In Frasnes, this therapeutic approach emerged through an ASBL encompassing a wide range of activities including sports, tourism, and development. In Chaudfontaine, a more specific association focused on adapted physical activities was created in collaboration with the University of Liège.

Although the Belgian social security system is considered high-level, providing quality care at reasonable costs, it has a notable weakness in prevention. Prevention, which could lead to future savings in curative treatments, has never been a priority in an institutional system where prevention and cure fall under different authorities. The paradigm of inclusion is now part of the institutional health culture in Europe. However, its

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implementation is often hindered by various barriers: legal/institutional, financial, and organisational/structural. Adapting the entire institutional system to these innovative new principles is a slow and complex process.

2.2 | Collaborative Efforts and Policy Insights on Active Ageing in Europe

From 2004 to 2007, 40 experts in APA for elderly individuals with and without disabilities from 29 European countries collaborated in the European Thematic Network funded by the European Commission, titled "Ageing and Disability—a New Intersection Between Physical Activity, Social Inclusion, and Life-long Well-being", also known as Thenapa 2. They convened a total of seven times over 3 days in various locations: Malta, Lithuania, Cyprus, Romania, Italy, Germany, and Austria. Their aim was to draw more attention to this pressing issue across European countries: enhancing the quality of life for elderly individuals with and without disabilities through increased physical activity. By 2050, nearly 37% of the European population will be aged 60 years or older, and research has unequivocally shown that increased physical activity significantly improves their quality of life (Van Coppenolle et al. 2011). Recent analyses confirm that countries implementing comprehensive active ageing policies tend to report higher levels of participation and improved health outcomes among older adults (Zaidi 2013).

A legal examination across states with diverse institutional structures, each presenting unique complexities and profiles, can offer valuable insights and reflections for shaping optimal policies and operational approaches in the realm of active ageing and health. Comparing the effectiveness of different welfare systems, especially concerning policies supporting individuals with disabilities, is a nuanced task. A credible evaluation demands a contextual analysis conducted with a holistic approach, giving due consideration to the myriad cultural and monetary aspects of the encompassing macro-system and its perspectives on disability.

For instance, while Italy may allocate fewer resources to long-term care and disability support policies, there exists an immense amount of unmonetisable family work (Da Roit 2007). This "intrafamily" caregiving represents a substantial portion of the "submerged" value within welfare resources.

Further exploration is warranted into the institutional culture in France and Belgium, where the significance of care institutions for the elderly and disabled is paramount, providing elevated levels of care. Nevertheless, ethical dilemmas emerge concerning the consequences of the nearly ubiquitous institutionalisation of elderly individuals, raising concerns about their freedom of choice and the somewhat coercive nature of the care provided (Salandini 2019).

2.3 | The Italian System

In Italy, the National Health Service establishes general guidelines and activities through the National Health Plan (Piano Sanitario Nazionale—PSN), aligned with national and international socio-economic objectives. The PSN, which is valid for 3 years, outlines draft guidelines, general directives, health priorities, and essential levels of assistance to ensure uniform conditions nationwide. These national guidelines are then adapted into Regional Health Plans (Piani Sanitari Regionali—PSR), which regulate local health services.

The National Prevention Plan (Piano Nazionale della Prevenzione—PNP) 2020 to 2025, which is integrated into the PSN framework, places greater emphasis on promoting physical activity across all age groups, including older adults (Ministero della Salute 2022). It focuses on prevention strategies such as hygiene interventions and lifestyle promotion to reduce disease incidence.

The Ministry of Health provides input on Regional Health Plans. At the local level, the General Director of the local health agencies (Azienda Sanitaria Locale—ASL) implements Local Implementation Plans (Piano di Attuazione Locale), operational tools translating health needs into networked actions.

Within the National Health System's (Sistema Sanitario Nazionale—SSN) prevention goals, ASLs offer services for the functional and social recovery of individuals with physical, mental, or sensory challenges. The PSN establishes Essential Levels of Assistance (Livelli Essenziali di Assistenza—LEA), not minimum but crucial areas of activity, ensuring uniformity and inclusivity regardless of income, location, religion, ethnicity, or gender. LEA also identifies macro-areas of assistance, adapting to evolving needs since 2017.

In "collective prevention and public health", SSN activities address infectious, environmental, and occupational risks. The Ministerial Decree (Decreto del Presidente del Consiglio dei Ministri—DPCM) 12/1/2017 defines social and health care as integrated services meeting health needs requiring health benefits and social protection actions.

Residential assistance covers extensive care and functional recovery, including long-term assistance with socialisation and animation activities. According to the National Institute of Statistics' (ISTAT) 2020 yearbook data for 2019, healthcare providers promote an active lifestyle among chronic patients only in 39% of cases, often due to the high costs associated with APA. There is an increasing demand within Local Health Authorities for non-healthcare settings for prevention and health promotion programmes, distinct from physiotherapy and rehabilitation treatments, aimed at replacing or supporting pharmacological therapies.

Costs for APA programs fall on citizens and are normally not deductible for tax purposes, distinct from therapeutic exercises led by physiotherapists.

Nevertheless, the Budget Law 2022 (Law No. 234/2021) introduces the "APA Bonus". This bonus provides a tax credit to individuals who incur documented expenses for APA undertaken between January 1 and December 31, 2022.

It is important to note that the APA Bonus applies exclusively to expenses incurred during the year 2022. The tax credit obtained

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can be used to reduce taxes due in the income tax return for the fiscal year 2022. Any unused amounts can be carried forward to subsequent years, but expenses incurred in subsequent periods cannot be claimed.

The absence of national standards hampers assessing regional services, relying on statistical standards. The National Institute for Public Policies Analysis (Istituto Nazionale per le Analisi delle Politiche Pubbliche—INAPP) notes issues in the Italian home care system, emphasising a lack of quality indicators and professional identity in social care services (Turchini 2019).

Public-private service distribution varies regionally, lacking uniformity. Coordination challenges arise from diverse procedural approaches, evaluation multiplicity, and communication gaps. Evaluation processes differ between residential and home-based care, the latter more revealing but delicate. Integration hurdles stem from administrative structures, uneven computerisation, and orogeographical characteristics affecting service networks.

Integration at the user level often involves practical development processes, sometimes delegating social-welfare activities to health companies. Alternatively, autonomous management ensures faster responses to health and social-welfare needs, overcoming limitations.

In Italy, according to the Legislative Decree of 28 February 36/2021, APA is typically health-oriented rather than illness-oriented. It is designed for adults or seniors, including those with pain syndromes due to reduced mobility or osteoporosis, individuals with clinically controlled and stabilised chronic conditions, or those with physical disabilities. The aim is to improve physical activity levels, promote socialisation, encourage healthier lifestyles, and recondition individuals at the end of a rehabilitation cycle (in this case, clinical and rehabilitative stability must be verified and properly documented by the medical-rehabilitation team). APA activities are recommended by the general practitioner (GP) or specialists and are conducted in groups under the supervision of adequately trained instructors.

In some regions, specific structured physical exercise programmes are already in place. These programmes involve the management and recommendation of physical activity for at-risk individuals through professional and organisational integration between GPs, chosen paediatricians, and specialists (sports medicine physicians, cardiologists, etc.). The administration, or the actual conduct of physical activity, takes place outside the healthcare service facilities, in venues and social spaces deemed suitable based on regional technical guidelines, which in some cases also include a certification and accreditation process (Ministero della Salute 2019).

2.4 | The French System

France boasts an intricate administrative structure at the territorial level, shaped by ongoing decentralisation since the 1980s, particularly impacting social and health policies (Bergeron and Castel 2018). This process has coincided with the establishment of inter-community units and significant municipal aggregations crucial for policy planning.

The French welfare system operates on the insurance principle, encompassing social security and social assistance for vulnerabilities. Approximately 90% of total welfare expenditure falls under the insurance pillar, covering risks related to pensions, health, family context, protection of minors, and job loss (DREES 2020). The second pillar provides various monetary benefits and interventions in kind, safeguarding individuals based on "fragility" criteria, categorised into "social aid" (aide sociale) and "social action" (action sociale).

"Social aid" includes legal benefits provided by departments to eligible citizens, while "social action" comprises optional social assistance interventions, primarily managed by municipalities. The state contributes to the "social aid" systems, ensuring equal benefits nationwide.

The French welfare system's expenditure and interventions follow a concentric circle scheme, covering various areas of intervention and a micro perimeter for non-self-sufficiency. Despite administrative decentralisation, central administrations largely allocate welfare resources, limiting departmental autonomy. The insurance-centric nature of the French system contributes to fragmentation.

In long-term care, assistance is bifurcated into support for the elderly and assistance for disabled individuals, regardless of age. Noteworthy among monetary interventions is the "Personalized Autonomy Allowance" (Allocation Personnalisée d'Autonomie), benefiting citizens over 60 and covering expenses for residential and home services based on assessed need levels.

Informal care plays a crucial role, with around three and a half million caregivers supporting vulnerable individuals (Blavet 2023). The state prioritises long-term care, while departments define policies and priorities for their territories. The National Solidarity Fund for Autonomy (Caisse Nationale de Solidarité pour l'Autonomie—CSA) at the central level coordinates services, ensuring homogeneity, and regional health agencies (Agences Régionales de Santé—ARS) plan and coordinate interventions in different regions.

In 2016, France institutionalised the prescription of APA for patients with long-term illnesses, aiming for de-medicalisation. This policy is part of a broader national strategy to promote active ageing and reduce health inequalities among older adults (Ministère des Solidarités et de la Santé 2023). Costs are sometimes covered by the health system, with insurance coverage for 30 chronic diseases. APA promotion policies operate through inter-ministerial approaches, with the Ministry of Health leading public health policies, emphasising APA in prevention and treatment.

The law of 26 January 2016 elevated APA's role in preventive medicine, recognising it as crucial in disease and autonomy prevention. The law of 28 December 2015 on societal adaptation to ageing acknowledges APA as a preventive factor. Public health plans, including National Nutrition and Health Program (Programme National Nutrition Santé—PNNS), emphasise APA in nutrition, chronic diseases, ageing, and environmental health. Overall, France has evolved policies supporting APA, emphasising its general interest and contribution to health objectives (Article 1 of the Sports Code).

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2.5 | The Belgian System

Belgium, like other European countries, grapples with the repercussions of an ageing society, such as an increased number of retirees, a declining workforce to finance retirement, rising medical care costs, and a growing number of dependents. These factors, coupled with changes in family structures, challenge the balance of the post-war social security system and give rise to a new vision of age: age as a *social risk* (Leisering and Leibfried 1999).

Despite efforts by the Federal Government to address care provision and demand accessibility, the Flemish Community deemed federal mechanisms insufficient in tackling the emerging social risk. As early as 1995, the Flemish Community introduced long-term care insurance, aiming to ensure accessible and high-quality services for all those in need of care in Flanders.

However, the French and Walloon Regions have not followed suit on the path of long-term care insurance. In 2004, the Walloon Government opted against creating such insurance, suggesting instead a reinforcement of APA (care allowance for the elderly).

The idea of long-term care insurance reappeared in 2018, initiated by Minister A. Greoli, emphasising its indispensability for self-sufficiency. The Walloon government had definitively adopted a decree aimed at establishing autonomy insurance in the Walloon Region. This initiative aimed to introduce a novel and solidarity-based social coverage to address the challenges posed by increasing life expectancy and loss of autonomy.

This insurance includes two distinct components:

- The first component offers home interventions by the Family and Elderly Care Services (SAFA), regardless of the age of the person experiencing loss of autonomy.
- The second component provides an autonomy lump sum allowance to individuals over 65 years old facing loss of autonomy and with modest incomes, whether they reside in nursing homes or at home.

In the absence of a legal framework, experiments with APA following the French model have emerged, blending preventive and curative approaches initiated by local agents. "Sports en prescription" is now available in four Walloon municipalities, with local non-profit organisations and various co-financing options facilitating its adoption.

While Belgium's social security system provides high-level care accessibility, a notable weakness is the lack of emphasis on prevention. Recent policy reviews highlight ongoing efforts to bridge this gap through community-based APA initiatives and the integration of preventive health measures (Belgian Federal Public Service Health 2023). The institutional system separates preventive and curative measures, hindering the incorporation of preventative measures that could save future costs.

The paradigm of inclusion is recognised in European institutional health culture, but its implementation faces legal, financial, and organisational barriers (Leahy and Ferri 2022). Adapting the entire institutional system to innovative principles is a slow process requiring macro-integration not only between institutions and individuals but especially between institutional levels. In Belgium, with its constitutional complexity, governance models and the role of the so-called second welfare are crucial for the success of innovative projects. The second welfare can play a fundamental role in bridging the gap between health demand and institutional responses, addressing cultural factors and contributing to a more comprehensive understanding of the "structural and relational" needs of the ageing population.

2.6 | Access to Services and Supporting Environments

While the organization of health and APA services is crucial, the broader environment in which older adults live also plays a vital role in shaping their quality of life and autonomy.

Active ageing policies in Europe increasingly recognise that well-being in later life depends not only on health and physical activity, but also on access to a wide range of essential services. Comparative studies show that older adults' quality of life is strongly influenced by the availability and affordability of healthcare, long-term care, housing, transportation, and adequate financial resources.

For example, a 2021 comparative assessment by the European Parliament found that, while France and Belgium provide relatively comprehensive long-term care coverage, Italy continues to face significant regional disparities and more limited access—particularly in southern regions. Housing adaptations and accessible transportation options also remain unevenly distributed, with persistent urban–rural divides in all three countries.

The European Pillar of Social Rights enshrines the right to resources that ensure dignity in later life, including adequate income, pension entitlements, and access to high-quality, affordable healthcare and long-term care services. However, the effective realisation of these rights still varies significantly across countries, and the COVID-19 pandemic has further exposed structural gaps in service accessibility for the elderly across Europe (European Parliament 2021).

3 | Rethinking Ageing: Sociological Knowledge and Institutional Practices

3.1 | A Holistic Understanding of Ageing and Quality of Life

Approaching the concept of quality of life ecologically involves considering not only physical health but also psychological well-being, satisfied social needs, and material living conditions. Ageing should be seen as a dynamic process, involving multidimensional development where the elderly remain the central

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characters in their evolution, spanning physical, spiritual, cultural, and emotional dimensions.

The loss of physical autonomy, often attributed to physical inactivity, can be addressed through APA and sports practices. Enhancing the physical conditions of the elderly contributes to a positive perception of health and well-being, fostering self-sufficiency and satisfaction (Yabe et al. 2012).

Life expectancy is influenced by various factors, and reacting to ageing dynamics involves a shift in habits and lifestyle. Here, institutions, particularly those facilitating APA, play a pivotal role in striking a balance between prevention and reaction.

Acknowledging that not all difficulties can be avoided, a revolution in the concept of services is essential. French sociology, with its concept of "déprise" (Caradec 2015), highlights the elderly's continuous negotiation to preserve their ideals amid social and biological implications.

Empowerment becomes crucial for the elderly to maintain self-esteem and autonomy. In the late stages of life, reduced social activities can lead to a feeling of "extraneity," emphasising the importance of interventions that reorganise pragmatic relationships.

3.2 | Care Models and the Role of Institutions and Professionals

Health professionals, especially general practitioners, play a key role in identifying sedentary elderly individuals and promoting APA. Gradual prevention actions and interventions conducted with basic counselling skills can help seniors adopt or maintain a more active lifestyle.

Addressing fragility in the elderly requires recognising not just physical but also social and psychological vulnerabilities. APA emerges as a crucial discriminator, with low levels strongly predicting fragility.

The paradigm of inclusion, though established in European institutional health culture, faces practical challenges. To be effective, micro-integration is necessary, emphasising collaborative action between institutions and individuals. New governance models hold potential for success and innovation.

Reflecting on representations of old age, concerns arise about the hyper-medicalization in the French and Belgian systems (Brond and Vercruyssen 2022). Preserving dignity and autonomy in prevention and APA promotion should not compromise the patient's freedom of choice.

The integration of APAs as a structural element in the care processes for the elderly promotes a culture of autonomy. This culture, embraced by both patients and multidisciplinary healthcare teams, enhances elders' freedom and ensures better professional well-being within the organization. By focusing on care, workers find an interdisciplinary dialogue space that adds meaning to their mission of support.

Internationally, social welfare policies emphasise the need for greater coordination between health and social services to address the increasing qualitative and quantitative demand for care. Qualitatively, social welfare policies risk becoming regressive in approaches and services offered, as well as in the technical and professional skills required. The urgent issue of population ageing, and the resulting chronic conditions necessitate a reassessment of governance strategies to ensure personalised care pathways that are accessible, effective, and sustainable.

Engaging elderly residents in activities that promote autonomy is a vital tool for empowerment and involvement. Overcoming institutional constraints and the oppression from losing control over their lives allows for the possibility of active citizenship, despite societal limitations on the elderly. Observations and professional exchanges reveal the need to shift from a strictly biomedical care model to a holistic approach. This shift requires the local and microstructural development of adapted physical activities.

Maslow's (1987) hierarchy of needs (1987) placed communication and affection after other needs, but Gineste and Marescotti's paradigm shift (Gineste et al. 2008) emphasises relational and communicative dynamics as foundational to individual identity throughout life. Relationships are crucial in shaping and confirming an individual's identity at every developmental stage.

Autonomy is central to relationships: at any developmental stage, an individual's identity forms and affirms through relationships. In care processes, consistently recognising the patient's autonomy—valuing their preferences, respecting their perception, sensitivity, and worldview—is essential. The patient is seen as a human and social animal, constantly interacting with their group and environment, while also being a unique individual with specific identities.

The main challenge lies in conceptual and theoretical shifts: to achieve a truly humanising approach, entrenched concepts in academic and cultural settings based on hierarchical needs must be abandoned. Recognising the patient as a human and social being means allowing them to define their own hierarchy of needs. Maintaining physiological function and physical health is as important as sustaining relational life to enable individuals to retain an autonomous and recognised identity.

3.3 | Towards a Multidimensional Model: Data and Indicators

Building on these reflections, it becomes evident that implementing such an inclusive model requires a stronger empirical foundation. While this article provides a theoretical and institutional framework for understanding the role of APA in active ageing policies, empirical data remain fragmented and, at times, difficult to compare.

For instance, according to Eurostat (2019), in 2019 only 7.4% of EU residents aged 65 and over met the recommended weekly levels of both aerobic and muscle-strengthening physical activity, with notable differences among France, Italy, and Belgium. These findings align with OECD data, which underscore

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persistent disparities in physical activity participation among older adults across Europe (OECD 2024).

Nevertheless, comparative multidimensional indicators do exist. The Active Ageing Index (UNECE/EC) for 2016–2018 reports differentiated scores across four key domains—employment, social participation, autonomy, and enabling environments—for the countries under study. Country-specific analyses for Italy, in particular, reveal pronounced regional and gender disparities in AAI performance.

Furthermore, data from Statbel (2023) and OECD (2024) indicate that 57.2% of Belgians engaged in sport at least once per week, surpassing the EU average of 55.9%, and pointing to the tangible implementation of APA programmes through both national and local initiatives.

The integration of such indicators—including participation rates, sport tax credits, public spending on prevention, and AAI scores—along with national datasets from ISTAT (Italy), DREES (France), and INAMI (Belgium), could provide a more robust basis for validating the proposed multidimensional model. Moreover, this approach would help identify best practices and structural weaknesses within each welfare system.

4 | Emerging Priorities in Active Ageing Policies

Beyond theoretical and institutional frameworks, several emerging challenges and strategic priorities are reshaping the landscape of ageing policies in Europe. These include intergenerational dynamics, digital inclusion, and the lessons learned from the COVID-19 pandemic—all of which are explored in the following section.

4.1 | Intergenerational Policies and Social Participation

Fostering intergenerational solidarity and social participation is key to building inclusive societies for all ages. Intergenerational solidarity is increasingly recognised as essential to social cohesion and the sustainability of welfare systems. The European Commission's upcoming Strategy on Intergenerational Fairness, set to launch in 2026, aims to strengthen communication and cooperation between generations in both the workplace and local communities. Initiatives promoting volunteering, mentoring, and community engagement among older adults not only combat social isolation but also enable the transfer of knowledge and experience across age groups.

The Active Ageing Index (AAI) includes indicators on social participation and shows that Belgium outperforms Italy and France in volunteering rates among people aged 65 and over (13% in Belgium versus 8% in Italy). Policies supporting intergenerational learning and civic engagement are associated with higher well-being and a more positive perception of ageing (UNECE and EC 2021).

4.2 | Digital Inclusion and Lifelong Learning

As societies become more digital, ensuring that older adults are not left behind is a growing policy concern. With public and private services increasingly moving online, digital inclusion has become a crucial dimension of active ageing. Yet older adults remain at high risk of digital exclusion: in 2022, only 25% of Europeans aged 65 to 74 used the internet daily, compared with 90% of those aged 16 to 24 (Eurostat 2023).

The digital divide is particularly acute in Italy and France, where digital literacy programs targeting older populations are less developed than in Belgium. Lifelong learning initiatives tailored to older adults can help close this gap, promoting cognitive functioning, social connectedness, and autonomy. The European Pillar of Social Rights affirms the right to quality and inclusive learning opportunities for all, regardless of age. Addressing gender and regional disparities in digital skills remains a key objective for policymakers aiming to ensure equitable access to services and full societal participation (European Commission 2025).

4.3 | The Impact of COVID-19 on Ageing Policies

The COVID-19 pandemic served as a stress test for ageing policies, revealing both strengths and critical vulnerabilities in existing systems (Esposito and Romualdi 2022). It had a profound impact on older populations, exacerbating inequalities in access to healthcare and social services, heightening social isolation, and accelerating the digitalisation of service provision. Countries with strong community-based support and digital outreach—such as Belgium—were better positioned to maintain service continuity for older adults.

At the same time, the pandemic exposed the limitations of institutional care models and underscored the need for more resilient, integrated, and person-centred approaches. The European Social Partners' report on the Framework Agreement on Active Ageing highlighted that workplace adaptations and health promotion measures were key to reducing job losses among older workers during the crisis.

Moving forward, the lessons learned are informing new strategies that emphasise prevention, social inclusion, and the empowerment of older adults (EU Social Partners 2021).

5 | Conclusion

In conclusion, the global demographic transition has thrust ageing to the forefront of societal challenges. Biologically, ageing triggers fragility with diverse indicators, while psychosocial challenges emerge from sedentary lifestyles. Policymakers face complex issues tied to an ageing population, emphasising the need for “active ageing”.

A transformative shift towards active ageing through PA and APA is crucial. Global health authorities stress that scaling up PA interventions is essential to meet the challenges of population

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ageing (WHO 2020). Our exploration of APA policies in Italy, France, and Belgium reveals diverse approaches influenced by cultural, monetary, and institutional factors. Each country faces unique challenges, from Italy's reliance on intrafamily caregiving to France's focus on long-term care insurance and Belgium's APA experimentation.

Integration of sociological knowledge and institutional approaches is vital for active ageing. Ageing should be viewed as a dynamic, multidimensional process, involving physical, spiritual, cultural, and emotional dimensions. Institutions, especially those facilitating APA, play a pivotal role in balancing prevention and reaction to ageing dynamics.

Recognising not all difficulties can be avoided, a revolution in the concept of services is crucial. French sociology's "déprise" concept underscores the elderly's continuous negotiation to preserve ideals. Empowerment is key for maintaining self-esteem and autonomy. Health professionals, especially general practitioners, play a crucial role in promoting APA.

Addressing fragility requires understanding physical, social, and psychological vulnerabilities. The paradigm of inclusion faces challenges, necessitating micro-integration between institutions and individuals. New governance models hold potential for success.

Concerns about hyper-medicalisation in French and Belgian systems underscore the need to preserve dignity and autonomy in APA promotion. Shifting from "persuasion" to "imposition" in well-being models may impact cognitive autonomy. Addressing gaps in the education system is crucial for effective prevention policies. In essence, a cultural and anthropological revolution, primarily through educational bodies, is crucial for transformative change in ageing and well-being.

Ethics Statement

This research does not involve any human participants or animals. The study consists solely of a comparative analysis of legal systems, based on textual and legal documentation. Therefore, no ethical approval was required for this research.

Consent

This research does not involve any human participants or animals. The study consists solely of a comparative analysis of legal systems, based on textual and legal documentation. Therefore, no consent to participate was required for this research.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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