

Concept Paper

Integrating the *Chinesiologo* AMPA into Italy's Adapted Physical Activity and Structured Physical Exercise Pathways: A Conceptual Model, Critical Policy Analysis, and Strategic Priorities

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Abstract

Physical activity supports prevention and chronic disease management, but the effective delivery of exercise programmes requires clearly defined responsibilities, access arrangements, including professional referral, delivery standards, and financing mechanisms. In Italy, Legislative Decree No. 36/2021 defines *attività fisica adattata* (AFA; adapted physical activity) and structured physical exercise (EFS) and specifies the functions of the *Chinesiologo delle Attività Motorie Preventive e Adattate* (*Chinesiologo AMPA*). Yet no coherent national pathway governs access to and coordinated delivery of these programmes. The reformulated amendment 4.47 to A.C. 2700 does not expressly include the *Chinesiologo AMPA* in its interdisciplinary framework, exposing an implementation gap in coordination among professional groups. This concept paper proposes an intersectoral, competence- and phase-based model linking clinical care with community-based prevention and exercise through AFA, EFS, and the long-term maintenance of physical activity. Six priorities follow: (i) alignment of emerging legislation with existing law; (ii) implementation of Article 41, especially through verifiable competence criteria under paragraph 8-bis; (iii) national standards for programme access, documented handover, reassessment, and accountability; (iv) explicit specification and financing of AFA and EFS pathways within the *Livelli Essenziali di Assistenza* (LEA; essential levels of care); (v) distinct rules for provider qualification, healthcare accreditation, and public contracting; and (vi) public, interdisciplinary, and intersectoral



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governance. The model preserves the responsibilities of healthcare professionals for diagnosis, treatment, and rehabilitation while operationalising, in qualified non-healthcare settings, the functions assigned to the *Chinesiologo AMPA* in prevention through exercise, adapted exercise programme design and delivery, and functional recovery after completion of rehabilitation. The inclusion of AFA and EFS in the LEA and their functional integration into *Servizio Sanitario Nazionale* pathways should be prioritised; formal recognition of the *Chinesiologo AMPA* within Italy's healthcare-professions framework could be considered only if the necessary political and institutional conditions are in place. Implementation of this model should ensure safe and documented transitions between clinical care and community-based prevention and exercise, equitable access to programmes, and outcomes assessed using shared indicators.

Keywords: adapted physical activity; structured physical exercise; *Chinesiologo AMPA*; exercise referral; essential levels of care; health policy; interprofessional collaboration; intersectoral governance

1. Why Implementation Requires Attention Now

Physical activity is a major determinant of health, function, and quality of life across the life course, including for people living with chronic conditions or disability [1]. Its policy relevance is equally clear: insufficient physical activity remains socially patterned and generates avoidable disease and expenditure across Europe [2]. The crucial policy question is how a public system can provide exercise that is appropriately assessed, individually dosed, safely supervised, and sustained beyond short-term projects or services purchased privately.

Clinical trials in cardiovascular populations have reported improvements in haemodynamic parameters, physical fitness, and selected health-status outcomes following multicomponent exercise [3,4]. In cancer survivorship, physical activity and functional indicators may contribute to the assessment of fatigue and psychological distress and to broader lifestyle-based strategies [5,6]. These studies illustrate the need for competent programme design, supervision, adherence support, and outcome monitoring, but they do not determine professional scope or reimbursement arrangements.

Evidence from exercise referral schemes also cautions against assuming that providing an exercise programme automatically produces sustained participation or improved outcomes: a systematic review found limited evidence of benefit and highlighted the need for stronger evaluation of programme uptake and effects [7]. This distinction between intervention efficacy and real-world service delivery is central to the present analysis.

Italy already has part of the legal architecture for such an approach. Article 2(1)(e), (t), and (ff) of Legislative Decree No. 36/2021 define *attività fisica adattata* (AFA; adapted physical activity), *esercizio fisico strutturato* (EFS; structured physical exercise), and the *palestra della salute*, respectively, while Article 41(3) requires an LM-67 master's degree and specifies the functions of the *Chinesiologo delle Attività Motorie Preventive e Adattate* (hereafter, *Chinesiologo AMPA*) [8]. Yet legal recognition has not become a nationally consistent service model.

This implementation deficit became visible during the parliamentary consideration of A.C. 2700. On 14 July 2026, the XII Committee of the Chamber of Deputies approved the reformulated version of amendment 4.47 concerning an interdisciplinary system for EFS. It expressly named specialists in sports medicine, general practitioners, paediatricians, and physiotherapists, and provided for protocols based on guidelines issued by the Italian

Sports Medicine Federation (FMSI) and validated by the *Istituto Superiore di Sanità* (ISS). It did not name the *Chinesiologo AMPA* [9]. Following the conclusion of committee examination on 8 October 2026, the provision was incorporated into Article 4(1)(d-ter) of the text reported to the Chamber of Deputies as A.C. 2700-A [10]. During the parliamentary debate on 12 October 2026, the Undersecretary of State for Health reiterated the interdisciplinary framework identifying sports medicine specialists, general practitioners, paediatricians, and physiotherapists, while a member of parliament explicitly referred to requests from graduates in exercise and sport sciences that had not been taken into consideration [11]. As of 16 October 2026, the bill remained under parliamentary consideration and had not entered into force [10].

In a parallel legislative track, on 12 May 2026 the Senate's 10th Standing Committee adopted a unified base text for Bills S.287 and S.1231 that would introduce EFS into the *Servizio Sanitario Nazionale* (SSN; Italian National Health Service) through a three-level model, regional accreditation and a national register of *palestre della salute*, and outcome monitoring; the text remains under committee examination and is not in force [12,13]. However, the adopted base text does not expressly coordinate this architecture with Articles 2 and 41 of Legislative Decree No. 36/2021, identify the *Chinesiologo AMPA*, or establish verifiable competence criteria; it also labels level II as *esercizio fisico adattato* (EFA) rather than the statutory AFA [8,12]. Moreover, its financial-invariance clause does not establish an ex ante funding mechanism, and the Senate Budget Committee requested a technical report after observing that implementation could generate new public expenditure and that savings verifiable only ex post could not ensure financial neutrality [12,14]. Subsequent amendments have sought to address some of these issues but remain pending and do not alter the adopted base text. Notably, the proposed designation of the *Chinesiologo AMPA* as a *figura di rilievo sanitario* does not amount to recognition as a healthcare profession and does not resolve the broader need for statutory alignment, clear professional functions, and consistent terminology for AFA and EFS [15].

Responses from professional and academic organisations confirm that the debate concerns both professional boundaries and service design. The *Federazione Nazionale degli Ordini della Professione Sanitaria di Fisioterapista* (FNOFI; Italian National Federation of Physiotherapy Orders) welcomed the express inclusion of physiotherapists [16] and subsequently published the dossier *Fisioterapista e Chinesiologo nell'ordinamento italiano*, addressing the legal status, education, competences, and fields of practice of physiotherapists and the statutory figure of the *Chinesiologo* [17]. The *Società Italiana delle Scienze Motorie e Sportive* (SISMeS; Italian Society of Movement and Sport Sciences) reported that the Conference of Italian University Rectors (CRUI) supported revising amendment 4.47 and including representatives of the *Chinesiologo AMPA* profession in the EFS working group [18]. These documents express institutional positions and should be distinguished from the statutory framework.

The available amendment text establishes which professional groups were expressly named, but the cited parliamentary and organisational documents do not establish a documented causal explanation for the *Chinesiologo AMPA* omission. In particular, they do not support an inference that a specific political pressure or alternative intervention displaced that profession. The omission is therefore treated here as a statutory-coordination issue rather than attributed to an unverified motive.

This concept paper examines the broader implementation problem revealed by the debate: how to connect existing competences through a pathway defined by clinical phase, purpose, setting, risk, and responsibility. The proposed model preserves the clinical responsibilities of physicians and physiotherapists while addressing service implementation under the current statutory framework and treating the possible formal recognition of the *Chinesiologo AMPA* within Italy's healthcare-professions framework as a separate, longer-

term policy question. It identifies how the functions already assigned to the *Chinesiologo AMPA* in prevention through exercise, adapted exercise programme design and delivery, and post-rehabilitation functional recovery can support AFA and EFS delivery and longer-term continuity, while preserving the legal scope of all professionals involved.

The conceptual contribution is therefore not a new clinical indication for exercise or a claim to exclusive professional practice. It is an implementation-oriented account of how statutory functions, clinical decision-making, delivery settings, professional capacity and public financing can be connected within a single accountable pathway. This emphasis on organisational context and the interaction of implementation determinants is consistent with the updated Consolidated Framework for Implementation Research [19], although that framework was not formally applied as an empirical coding instrument.

Scope and Analytical Approach

This non-empirical concept paper draws on a focused, non-systematic examination of enacted Italian legislation, parliamentary texts, official institutional and professional documents, and selected peer-reviewed research directly relevant to AFA and EFS pathways and service implementation. The sources were examined to distinguish legal requirements from pending proposals and organisational positions, to identify gaps affecting access and interprofessional coordination, and to develop an intersectoral, competence- and phase-based pathway linking clinical care with community-based prevention and exercise programmes in qualified non-healthcare settings. The literature was selected for relevance to these questions rather than through a systematic search or formal evidence grading; no primary data were collected.

2. Statutory Framework and Professional Roles

2.1. AFA, EFS, and the Chinesiologo AMPA

Article 2(1)(e), (t), and (ff) of Legislative Decree No. 36/2021 define AFA, EFS, and the *palestra della salute*, respectively. Although adapted physical activity is commonly abbreviated as APA in the English-language scientific literature, AFA is retained throughout this paper when referring to the specific statutory category defined by Italian legislation [8]. AFA and EFS are delivered in non-healthcare settings, including *palestre della salute*. AFA comprises exercise programmes whose type and intensity are defined through professional and organisational integration among general practitioners, paediatricians, and specialists and calibrated to the functional conditions of the people for whom they are intended. These programmes are intended for people with physical disabilities or clinically controlled and stabilised chronic conditions and are performed in groups under the supervision of a professional with specific competences. Their aims are to increase physical activity, improve well-being and quality of life, and promote socialisation. EFS consists of planned and repeated programmes defined through professional and organisational integration among general practitioners, paediatricians, and specialists on the basis of each individual's clinical condition. It is intended for people with diseases or health risk factors, is performed individually under the supervision of a professional with specific competences, and is directed towards maintaining or improving physical fitness, physical performance, and health. A *palestra della salute* is a public or private non-healthcare facility in which AFA and EFS programmes are delivered [8].

Article 41(3) assigns the *Chinesiologo AMPA* functions that include the design and implementation of motor-activity programmes; the organisation of activities and lifestyles for disease prevention and improved quality of life through exercise; post-rehabilitation functional recovery; and the programming, coordination, and evaluation of adapted motor activities for people with disabilities or clinically controlled and stabilised health conditions.

In *palestre della salute*, Article 41(8) provides for collaboration with specialists in sports and exercise medicine, physical and rehabilitation medicine, and nutrition science, as well as relevant healthcare professionals, including physiotherapists and dietitians [8]. The 2022 corrective decree added paragraph 8-bis to Article 41: group AFA and individual EFS are supervised by a *Chinesiologo AMPA* or another professional possessing specific competences [20].

Taken together, these provisions recognise the *Chinesiologo AMPA* as a graduate professional with defined functions in prevention through exercise, adapted exercise programme design and delivery, clinically controlled and stabilised conditions, and post-rehabilitation functional recovery. They do not classify the *Chinesiologo AMPA* as a healthcare professional or assign diagnosis, medical treatment, or clinical rehabilitation. They also do not establish a nationally guaranteed service, provide for dedicated posts in the public system, define a reimbursement mechanism, or establish exclusive professional rights over exercise. Implementation therefore requires rules governing access, supervision, handover, quality, accountability, and financing.

For international readers, the *Chinesiologo AMPA* is not a physiotherapist under a different title. Italian law requires a second-cycle university degree in the LM-67 class, following earlier university study, and assigns functions in preventive and adapted exercise, programme design, supervision and post-rehabilitation functional recovery; this qualification is not obtained through a short certification course [8]. By contrast, the physiotherapist is a legally recognised healthcare professional with responsibilities in clinical rehabilitation under Ministerial Decree No. 741/1994 [21]. Neither title should be treated as directly equivalent to clinical exercise physiology credentials used in other countries. The statutory *Chinesiologo AMPA* is also unrelated to “applied kinesiology”, a complementary or alternative practice associated with diagnostic interpretations of manual muscle testing [22].

2.2. Interfaces with Medical and Physiotherapy Practice

The physiotherapist is a healthcare professional under Ministerial Decree No. 741/1994. With reference to the physician’s diagnosis and prescriptions, and within the profession’s competences, the physiotherapist formulates the rehabilitation programme, including as part of a multidisciplinary team, and independently carries out therapeutic activities for functional re-education [21]. The proposed framework leaves this scope unchanged. When a person requires medical assessment, clinical treatment, or rehabilitation because of an acute or unstable condition, diagnostic uncertainty, or other clinical complexity, care should remain within the appropriate clinical care pathway.

A chronic diagnosis does not make every subsequent exercise session an act of diagnosis, treatment, or clinical rehabilitation. The statutory categories differ: AFA expressly concerns people with clinically controlled and stabilised chronic conditions or physical disabilities, whereas EFS concerns people with diseases or health risk factors and is defined according to each individual’s clinical condition [8]. Both are performed in non-healthcare settings under professional supervision. The national physical activity guidelines also promote coordination among healthcare services and other institutional and community actors in strategies addressing physical inactivity and chronic disease [23]. Clear referral, handover, and reassessment rules are therefore needed across the continuum from clinical care to sustained physical activity.

3. Therapeutic Exercise, Professional Scope, and Service Context

Recent institutional debate has used “therapeutic exercise” as a category for defining professional scope [17]. Exercise delivered as part of clinical treatment or rehabilita-

tion requires the competences and accountability of the relevant healthcare professionals. However, in the provisions examined here, “therapeutic exercise” does not operate as an autonomous statutory category that, by itself, assigns every health-oriented exercise intervention to one profession [8,21]. The legal classification depends on the purpose and context of the service, the person’s clinical phase and needs, and the responsibilities assumed by the professional.

Walking, resistance, balance, and mobility exercises may be used in different services. During active rehabilitation, they may address an impairment within a physiotherapy programme and be adjusted through clinical reasoning. In AFA or EFS, similar exercises may be used in a non-healthcare setting to maintain function, increase physical activity, improve fitness, or support participation. Responsibility therefore follows the service context and the professional acts performed rather than the visible form of the exercise.

Table 1 sets out the proposed responsibilities and transition points across the pathway. It represents an operational interpretation of the current statutory framework rather than a catalogue of reserved acts. Professional contributions may be sequential or concurrent, and reassessment must remain possible whenever symptoms, risk, or functional status change [8,20,21].

Table 1. Proposed responsibilities and transition points across the exercise pathway.

Phase or Need	Purpose and Primary Responsibility	Contribution of the <i>Chinesiologo AMPA</i>	Handover or Escalation
Clinical assessment or diagnostic uncertainty	Establish diagnosis, assess clinical stability and contraindications, and determine the need for clinical treatment or rehabilitation. Medical responsibility lies with the physician, with contributions from relevant healthcare professionals within their respective scopes.	May provide activity history and exercise-related observations from prior contact and refer for medical assessment when indicated; does not undertake diagnosis.	Communicate clinical information, precautions, and risk parameters when entry to AFA or EFS is appropriate.
Clinical treatment or active rehabilitation	Address pathology-related impairment or other clinical needs. Responsibility lies with the relevant healthcare professionals within their legal scopes; with reference to the physician’s diagnosis and prescriptions, the physiotherapist formulates the rehabilitation programme and independently carries out therapeutic activities for functional re-education.	Does not replace clinical treatment or rehabilitation; separate concurrent AFA or EFS participation may occur in a qualified non-healthcare setting when clinically appropriate and responsibilities are documented.	Use documented criteria for entry or transition to AFA or EFS and reassess when clinical status changes.
Post-rehabilitation transition	Preserve functional gains and support continuity after time-limited rehabilitation through a documented handover.	Translate relevant functional information into a progressive adapted programme within professional scope.	Provide feedback to the referring team and request reassessment for red flags, deterioration, or unmet criteria.
Group AFA	Increase physical activity, well-being, quality of life, and socialisation in people with physical disabilities or clinically controlled and stabilised chronic conditions. Supervision follows Article 41(8-bis).	When acting as the supervisor under Article 41(8-bis), the <i>Chinesiologo AMPA</i> designs, adapts, supervises, and evaluates the group programme, thereby applying the functions in prevention through exercise and adapted exercise programme design and delivery established by Article 41(3).	Undertake periodic review and request clinical reassessment if health status changes.

Table 1. Cont.

Phase or Need	Purpose and Primary Responsibility	Contribution of the <i>Chinesiologo AMPA</i>	Handover or Escalation
Individual EFS	Maintain or improve fitness, physical performance, and health in people with disease or health risk factors, according to their individual clinical condition. Supervision follows Article 41(8-bis).	When acting as the supervisor under Article 41(8-bis), the <i>Chinesiologo AMPA</i> individualises the programme, supervises delivery, monitors predefined responses, and reports agreed outcomes in accordance with the functions established by Article 41(3).	Suspend the programme and refer when predefined thresholds or red flags are met.
Long-term maintenance following AFA or EFS	Sustain physical activity and participation, with professional support proportionate to individual need and risk.	Support progression, adherence, and reassessment of exercise-related outcomes.	Arrange scheduled review or return to clinical assessment when indicated.

Note: This table presents the authors' proposed operational framework. Statutory definitions, functions, collaboration, supervision, and setting requirements are derived from Legislative Decree No. 36/2021, Article 2(1)(e), (t), and (ff), and Article 41(3), (8), (8-bis), and (9), as amended, and Ministerial Decree No. 741/1994 [8,20,21]. It does not define reserved acts or replace case-specific clinical judgement.

The proposed model clarifies professional responsibilities by linking them to the purpose, setting, and clinical phase of the service. Diagnosis, medical treatment, and clinical rehabilitation remain within the remit of the legally competent healthcare professionals. Within AFA and EFS, the *Chinesiologo AMPA* can perform the functions assigned by Article 41(3) in prevention through exercise, adapted exercise programme design and delivery, and post-rehabilitation functional recovery for the populations and settings specified by law [8,20]. Documented referral, handover, and escalation procedures would also enable participants to understand who is responsible at each stage.

4. From Legal Recognition to Service Delivery

Physical activity is already addressed within Italy's *Livelli Essenziali di Assistenza* (LEA; essential levels of care). The 2017 provisions include health promotion, individual counselling, and the promotion of structured physical exercise programmes for people at risk [24,25]. They therefore provide a policy basis for physical activity but do not define AFA or EFS as nationally specified service pathways.

What remains absent is a sufficiently explicit and uniform specification of AFA and EFS, as subsequently defined by Legislative Decree No. 36/2021, with national eligibility criteria, referral and transition rules, minimum content, quality requirements, outcome measures, and sustainable funding. Regional initiatives demonstrate feasibility but also variation in terminology, access, provider requirements, and payment. Our earlier analysis documented these differences through the lenses of health citizenship, equity, and LEA inclusion [26]. The present paper focuses more narrowly on the operational architecture required to make these pathways safely accessible, measurable, and financially sustainable while preserving professional scope.

Ministerial Decree No. 77/2022 provides a potentially useful territorial platform through Community Health Houses, territorial services, prevention, and continuity of care, but it does not itself define an AFA or EFS pathway or assign a role to the *Chinesiologo AMPA* [27]. Consequently, the legal recognition of AFA, EFS, and relevant professional functions and the reorganisation of territorial healthcare services remain insufficiently connected. In the absence of national specifications, access may depend on local initiatives or private payment, while healthcare providers and qualified non-healthcare exercise providers lack common rules for referral, handover, information exchange, and outcome

evaluation. This fragmentation also limits comparison of uptake, adherence, safety, and outcomes across Regions.

The gap is organisational as well as legal. Article 41(3) defines the functions of the *Chinesiologo AMPA*, paragraph 8 describes interprofessional collaboration in *palestre della salute*, paragraph 8-bis assigns supervision of group AFA and individual EFS to the *Chinesiologo AMPA* or another professional possessing specific competences, and paragraph 9 allocates structural and staffing requirements to the Regions and Autonomous Provinces [8,20]. Yet paragraph 8-bis does not specify verifiable criteria for identifying that other professional, and these provisions do not establish a nationally guaranteed or funded service. Conversely, naming a profession in legislation without specifying access, quality standards, and funding would not ensure equitable delivery. A national pathway must therefore address both professional interfaces and public contracting.

Implementation of the statutory AFA and EFS framework and development of LEA-funded pathways constitute the priority route to functional integration. In the longer term, only if the necessary political and institutional conditions are in place, formal recognition of the *Chinesiologo AMPA* within Italy's healthcare-professions framework could be evaluated through the separate statutory procedure under Article 5 of Law No. 43/2006, as replaced by Article 6 of Law No. 3/2018 [28].

5. An Intersectoral Competence- and Phase-Based National Pathway

A national model should use five decision variables: (1) clinical stability and diagnostic certainty; (2) the presence of a clinical treatment or rehabilitation need; (3) exercise-related risk and monitoring requirements; (4) the primary purpose of the intervention; and (5) the setting and phase of the pathway. Taken together, these variables provide a clearer basis for defining responsibilities and transitions than diagnosis, location, or the expected health benefit of exercise alone.

Entry should be possible from general practice, paediatrics, specialist care, rehabilitation services, prevention departments, or other authorised channels. Medical assessment should be required when needed to establish diagnosis, clinical stability, contraindications, or risk parameters. It should not be duplicated when recent and adequate clinical information is already available. A standardised referral should include the relevant condition, a statement of clinical stability, current treatment, precautions, individualised thresholds, stopping criteria, and the timing of reassessment. It need not prescribe every exercise variable that falls within the competence of the professional supervising the programme.

When clinical treatment or rehabilitation is required, those interventions remain within the appropriate clinical care pathway. Entry or transition to AFA or EFS should follow explicit criteria and a concise functional handover. Concurrent participation may be appropriate in some cases if the person is clinically suitable and professional responsibilities are documented. In a qualified non-healthcare setting, the *Chinesiologo AMPA* can, within professional scope and without undertaking diagnosis, evaluate exercise-relevant functional capacity, design and progress programmes, support adherence, monitor predefined responses, and communicate outcomes, thereby applying the functions in prevention through exercise, adapted exercise programme design and delivery, and post-rehabilitation functional recovery assigned by Article 41(3). New symptoms, deterioration, unexpected responses, or breached thresholds should lead to programme suspension and clinical reassessment through an agreed escalation protocol. Clear routes back to clinical assessment are therefore as important as entry routes.

Figure 1 translates these principles into the proposed pathway. It begins with a review of available clinical information and, where indicated, further assessment of stability, rehabilitation need, and exercise-related risk. Its central feature is a bidirectional interface

between the clinical care pathway and a community-based prevention and exercise pathway delivering AFA and EFS in qualified non-healthcare settings, allowing documented transition, coordinated concurrent participation where appropriate, scheduled review, outcome feedback, and return to clinical assessment when red flags, deterioration, or breached thresholds arise.

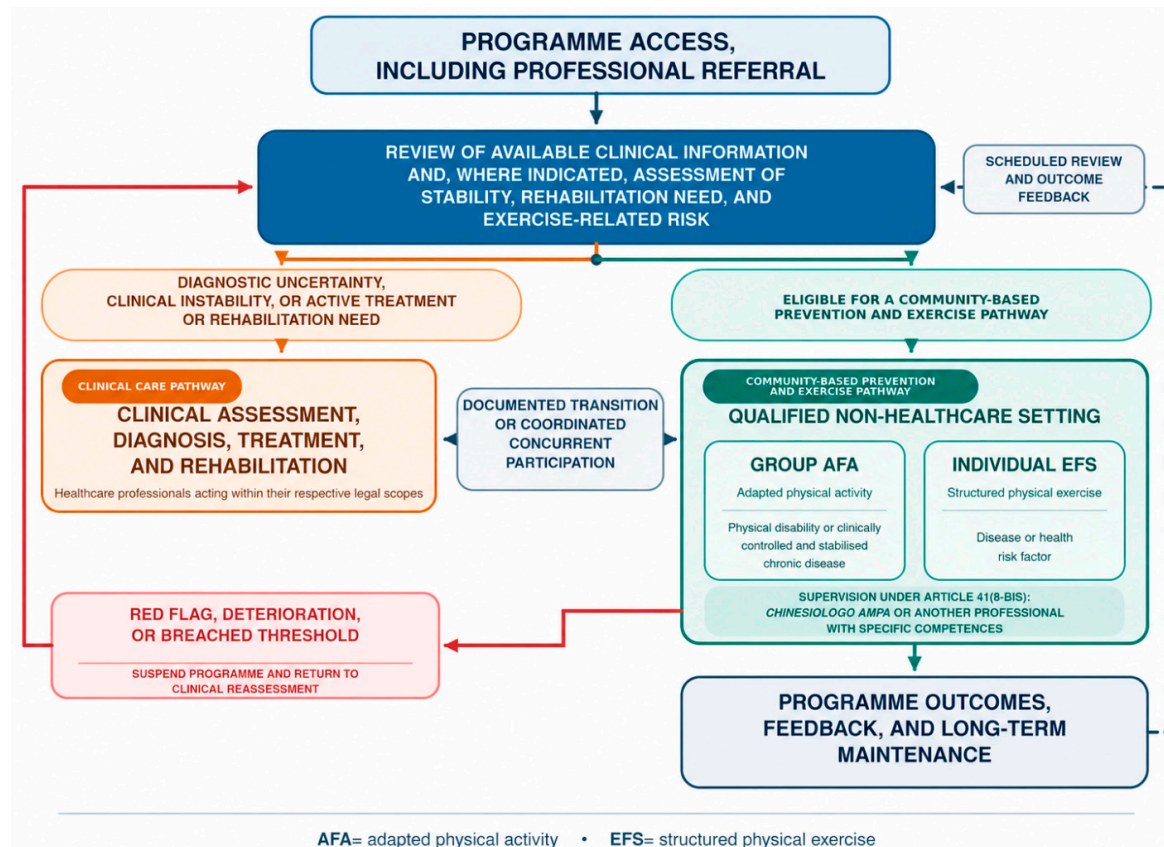


Figure 1. Proposed intersectoral, competence- and phase-based pathway linking clinical care with community-based prevention and exercise through adapted physical activity and structured physical exercise. At entry, available clinical information is reviewed and, where indicated, further assessment is undertaken to determine diagnostic certainty, clinical stability, treatment or rehabilitation need, and exercise-related risk. Clinical assessment, diagnosis, treatment, and rehabilitation remain the responsibility of healthcare professionals acting within their respective legal scopes. Group AFA and individual EFS are delivered in qualified non-healthcare settings and supervised under Article 41(8-bis) by the *Chinesiologo AMPA* or another professional with specific competences [8,20]. Documented transitions, coordinated concurrent participation, scheduled review, and outcome feedback support continuity; red flags, deterioration, or breached thresholds trigger programme suspension and return to clinical reassessment. *Source:* authors' elaboration. The figure was prepared with the assistance of ChatGPT Images 2.0 (OpenAI); its conceptual content and terminology were reviewed and verified by the authors.

For interoperability, all Regions should adopt a minimum national dataset: eligibility and referral source; waiting time; baseline functional and physical activity measures; programme type, dose, and completion; adherence and dropout; relevant participant-reported outcomes; adverse events and escalations; periodic clinical reassessment where indicated; and post-programme maintenance. A minimum dataset would support national audit and comparison while keeping documentation proportionate to the setting and level of risk.

These indicators should distinguish implementation outcomes, such as acceptability, adoption, feasibility, fidelity and sustainability, from participant-level health or functional effects, since improvement in one domain does not establish success in the other [29].

Outcome measurement should be limited to the information required for quality improvement, safety, and evaluation. A small set of validated, low-burden measures can be collected at entry, completion, and an agreed follow-up point, with additional monitoring proportionate to risk. At regional and national levels, aggregate results should be stratified, where numbers permit, by age, sex, disability, socioeconomic position, and geography so that favourable average outcomes do not conceal inequities in access or completion. Appropriate data-protection arrangements are required, but continuity of information does not require every non-healthcare provider to have unrestricted access to the clinical record. For most cases, a structured referral, a secure feedback channel, and role-based access to the minimum necessary information should suffice. National specifications should distinguish adverse events and safety incidents from expected exercise-related responses and should support appropriate risk adjustment when programmes are compared. This would facilitate learning while reducing incentives to select only lower-risk participants.

The selection of indicators is also compatible with the RE-AIM dimensions of reach, effectiveness, adoption, implementation and maintenance [30]. These established evaluation constructs are used here to motivate measurable recommendations, not to claim that the proposed Italian pathway has already been tested.

6. Priorities for National Implementation

The following six priorities integrate the statutory and institutional analysis with evidence on exercise referral schemes [7], implementation determinants [19], and established approaches to evaluating implementation and public health outcomes [29,30]. They represent proposed directions for national implementation rather than empirically validated effects of the conceptual model.

6.1. Include the *Chinesiologo* AMPA and Align the Emerging EFS Frameworks with Existing Law

Article 41(3) establishes the statutory functions of the *Chinesiologo* AMPA in relation to AFA and EFS, as defined in Article 2(1)(e) and (t); Article 41(8) provides for collaboration in *palestre della salute*; and Article 41(8-bis) addresses supervision of group AFA and individual EFS [8,20]. The emerging EFS frameworks under A.C. 2700 [10] and the unified Senate base text for Bills S.287 and S.1231 [12] should be aligned with this existing statutory framework. Including the *Chinesiologo* AMPA need not alter the express inclusion of physiotherapists; the text should clarify that each professional contributes according to legal scope and pathway phase, without granting any profession general or exclusive authority over exercise.

6.2. Operationalise Article 41 and Clarify “Another Professional Possessing Specific Competences”

Article 41(9) assigns the Regions and Autonomous Provinces responsibility for establishing structural and staffing requirements for exercise routes, parks, and *palestre della salute* [8]. National minimum standards should therefore be developed through an appropriate State–Regions mechanism, while preserving regional responsibility for implementation. The most immediate unresolved competence issue lies in paragraph 8-bis: it expressly identifies the *Chinesiologo* AMPA but does not define how “another professional possessing specific competences” is to be identified [20]. Transparent national criteria for eligibility to supervise AFA and EFS are therefore required and should be based on verifiable qualifications and competences. Short courses or continuing education may supplement, but

should not replace, a relevant qualifying degree or a regulated professional qualification accompanied by verifiable exercise-specific competences.

For example, responsible authorities could verify the relevant qualifying degree or regulated professional qualification, inspect documented learning outcomes and exercise-specific coursework, and assess evidence of practical competence in programme adaptation, exercise-risk recognition and supervision. Such assessment should use transparent, documented criteria consistent with each profession's existing legal functions; it would not create an exclusive reserved act for the *Chinesiologo AMPA* or exclude other qualified professionals by title alone.

6.3. Standardise Access, Handover, and Accountability

A national pathway should specify eligibility, referral information, initial risk stratification, programme documentation, participant information and consent where required, emergency procedures, red flags, communication intervals, and criteria for reassessment or transfer. Every participant should know who is responsible for clinical decisions, who supervises the programme, and whom to contact if status changes. Regions may organise delivery differently, but minimum standards for safety, information, and accountability should be uniform nationally.

Standardisation must be matched by capacity. A referral pathway cannot provide effective access without a sufficiently large qualified workforce, suitable facilities, and funded places. Regional plans should estimate demand, map the qualified workforce, including *Chinesiologi AMPA* holding an LM-67 degree, identify suitable and accessible facilities, and address transport and digital barriers. They should also specify links with primary care and rehabilitation services and plan the geographical distribution of funded provision. Workforce development should include supervised practice, pathway-specific continuing professional development, and competencies for communication with clinical teams.

6.4. Develop a Formal LEA Proposal for AFA and EFS

Specification of AFA and EFS as LEA pathways requires more than terminological inclusion. A formal update proposal should define target populations, evidence, expected outcomes, the delivery model, resource implications, and monitoring indicators through the established Ministry of Health process [31,32]. The dossier should include budget-impact and cost-effectiveness analyses, distributional effects, and a staged implementation plan. If these pathways are incorporated into the LEA, access should not depend on the ability to pay privately. Importantly, inclusion of a pathway in the LEA would concern service guarantees and financing. The possible future formal recognition of the *Chinesiologo AMPA* within Italy's healthcare-professions framework would be considered through the separate statutory procedure [28].

Eligibility should not rely on a closed disease list alone. Clinical stability, functional need, inactivity, modifiable risk, likely benefit, and the ability to participate safely are more useful allocation criteria, with disease-specific protocols added where necessary. A staged national rollout could initially prioritise people completing rehabilitation, those with stable high-burden chronic conditions, and groups facing financial or geographic barriers, while generating evidence for expansion. Such prioritisation must be explicit and time-limited, with published coverage targets, rather than an implicit rationing system determined by local initiative.

6.5. Separate Provider Qualification, Healthcare Accreditation, and Public Contracting

Healthcare authorisation and accreditation are governed by Legislative Decree No. 502/1992 and regional implementation [33]. By contrast, Article 2(1)(ff) defines a *palestra della salute* as a non-healthcare facility, and Article 41(9) assigns the Regions and Au-

onomous Provinces responsibility for establishing structural and staffing requirements for exercise routes, parks, and *palestre della salute* [8]. A coordinated national–regional framework should establish minimum requirements for premises, equipment, accessibility, professional qualifications, emergency readiness, information governance, insurance, audit, and outcome reporting. Delivery of the statutory AFA and EFS pathways defined in Article 2(1)(e) and (t) within healthcare or health and social care facilities would require express legislative coordination with Article 2. Until then, exercise interventions in those settings should be classified under the rules applicable to the relevant healthcare or health and social care service [8].

For qualified non-healthcare AFA and EFS providers, qualification should establish eligibility to deliver the pathway, while a regional recognition mechanism should confirm continuing compliance with the applicable standards. Healthcare accreditation should apply only where the provider and service fall within the healthcare framework. Contracting or commissioning determines whether and how the provider is paid from public funds. These stages should remain distinct: recognition alone does not create an entitlement to reimbursement.

Recent regional developments reinforce this distinction. Alongside more established regional experiences previously analysed [26], Liguria and Calabria have recently adopted implementing instruments establishing procedures and requirements for the recognition or certification of non-healthcare *palestre della salute* [34,35]. These measures confirm the feasibility of translating the provider framework envisaged by Article 41 into concrete regional standards. At the same time, their regional and provider-focused nature shows that such implementation cannot, by itself, substitute for national LEA specification, uniform access rules, and public contracting.

Internationally, national professional standards for clinical exercise physiology have been established in Australia, Canada, New Zealand, the United States, and the United Kingdom [36]. In Australia, Medicare supports exercise physiology services delivered by eligible exercise physiologists to patients with chronic conditions and complex care needs under defined care-planning and referral requirements [37]. These foreign professional categories and service arrangements are not direct legal equivalents of the Italian professional and statutory framework governing the *Chinesiologo AMPA*. Their relevance is functional: they demonstrate that professional competencies, provider qualification, pathway entry, accountability, and public payment can be specified through distinct but coordinated mechanisms, thereby supporting the competence- and phase-based model proposed here.

6.6. Establish Public, Interdisciplinary, and Intersectoral Governance

Because a pathway within the SSN entails public accountability, its governance should be led by the Ministry of Health, technically supported by the ISS, and developed with the Regions and Autonomous Provinces. Universities, FMSI, relevant scientific societies, representatives of exercise and sport science professions, medical and other healthcare professions, and patient and disability organisations should contribute according to their expertise. FMSI guidelines may provide important scientific input, while ISS validation may strengthen methodological quality [9]. Protocol development, approval, and revision should nevertheless remain interdisciplinary, intersectoral, and publicly accountable. Methods for grading evidence, management of conflicts of interest, revision cycles, and stakeholder consultation should be transparent.

Implementation should begin with time-limited pilots in diverse regions, but pilots must be designed for scale rather than used as a substitute for national action. Predefined evaluation should cover reach, equity, safety, functional outcomes, adherence, quality of

life, healthcare utilisation, and costs. Results should inform an annual national report and scheduled protocol revisions.

7. Shared Responsibilities for Implementation

A durable policy solution must preserve clinical safeguards without treating all health-oriented exercise as healthcare. Physicians retain responsibility for medical diagnosis, medical assessment of clinical stability, and medical decision-making. Physiotherapists retain the functions assigned by their professional framework, including the formulation of rehabilitation programmes and therapeutic activity for functional re-education. Under current law, the *Chinesiologo AMPA* is a graduate professional not classified as a healthcare professional. The functions assigned by Article 41(3) for prevention through exercise, adapted exercise programme design and delivery, clinically controlled and stabilised conditions, and post-rehabilitation functional recovery should be operationalised through defined services, standards, and professional interfaces [8,20,21].

For the exercise and sport science community, implementation requires service accountability alongside professional recognition: verifiable competences, documented outcomes, red-flag recognition and escalation, continuing professional development, and participation in interdisciplinary audit. For healthcare professions, it requires structured referral, handover, and reassessment arrangements that connect clinical care with sustained exercise when AFA or EFS is appropriate. For policymakers, it requires regulation and financing of both service delivery and the transitions at which continuity is most vulnerable.

8. Conclusions

The omission of the *Chinesiologo AMPA* from the reformulated amendment 4.47 illustrates a wider implementation gap. Correcting that omission would improve coherence between the emerging EFS framework and existing law, but would not by itself establish a deliverable service [8,9,20]. Italy already has statutory definitions of AFA and EFS under Article 2(1)(e) and (t), a definition of the *palestra della salute* under Article 2(1)(ff), defined *Chinesiologo AMPA* functions under Article 41(3), collaboration and supervision provisions under Article 41(8) and (8-bis), regional implementation responsibility under Article 41(9), a territorial-care reform, and LEA provisions addressing structured exercise [8,20,24,25,27]. What it lacks is a nationally specified, funded, and evaluable pathway connecting these elements.

An intersectoral, competence- and phase-based model can preserve responsibility for medical diagnosis, clinical treatment, and rehabilitation while giving operational effect to the functions assigned to the *Chinesiologo AMPA* for the populations and settings defined by law. The policy strategy should therefore proceed on three levels. First, in the immediate term, the emerging legislative framework should be aligned with existing law and Article 41 should be operationalised, giving priority to transparent and verifiable criteria for identifying the “other professional possessing specific competences” under paragraph 8-bis, alongside coordinated implementation of paragraphs 3, 8, and 9 [8,20]. Second, as the priority service-delivery route, AFA and EFS pathways should be specified and financed within the LEA, with national rules for eligibility, referral, handover, reassessment, provider qualification, public recognition, commissioning, accountability, intersectoral governance, and outcomes. Third, in the longer term, only if the necessary political and institutional conditions are in place, formal recognition of the *Chinesiologo AMPA* within Italy’s healthcare-professions framework and its possible implications for access to health-sector roles could be evaluated through the statutory procedure under Article 5 of Law No. 43/2006, as replaced by Article 6 of Law No. 3/2018 [28]. These three levels are distinct but potentially complementary. Together, they form an intersectoral architecture linking clinical

care, prevention through exercise, and community-based AFA and EFS delivery while preserving the distinct legal status, responsibilities, and settings of the professionals and services involved. Success should be judged by whether citizens can access these pathways and move safely and equitably between clinical care and sustained physical activity as their needs change.

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