

EMPOWERING LIVES THROUGH KNOWLEDGE AND IMAGINATION

MILANO | ITALY

Nessuno si siede a tavola per mangiare un piatto di nutrienti: la prospettiva di uno scienziato sociale

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5 Ottobre 2018

Nutrizione e salute

Il cibo è un determinante fondamentale della salute

- Sottonutrizione (paesi poveri, aree in paesi a basso-medio reddito; fasce specifiche anche nei paesi ricchi)
- Sovranutrizione (fenomeno globale)
- Malnutrizione (fenomeno globale)

Global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013: a systematic analysis for the Global Burden of Disease Study 2013

Summary

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Background In 2010, overweight and obesity were estimated to cause 3·4 million deaths, 3·9% of years of life lost, and 3·8% of disability-adjusted life-years (DALYs) worldwide. The rise in obesity has led to widespread calls for regular monitoring of changes in overweight and obesity prevalence in all populations. Comparable, up-to-date information about levels and trends is essential to quantify population health effects and to prompt decision makers to prioritise action. We estimate the global, regional, and national prevalence of overweight and obesity in children and adults during 1980–2013.

Methods We systematically identified surveys, reports, and published studies (n=1769) that included data for height and weight, both through physical measurements and self-reports. We used mixed effects linear regression to correct for bias in self-reports. We obtained data for prevalence of obesity and overweight by age, sex, country, and year (n=19244) with a spatiotemporal Gaussian process regression model to estimate prevalence with 95% uncertainty intervals (UIs).

Findings Worldwide, the proportion of adults with a body-mass index (BMI) of 25 kg/m² or greater increased between 1980 and 2013 from 28·8% (95% UI 28·4–29·3) to 36·9% (36·3–37·4) in men, and from 29·8% (29·3–30·2) to 38·0% (37·5–38·5) in women. Prevalence has increased substantially in children and adolescents in developed countries; 23·8% (22·9–24·7) of boys and 22·6% (21·7–23·6) of girls were overweight or obese in 2013. The prevalence of overweight and obesity has also increased in children and adolescents in developing countries, from 8·1% (7·7–8·6) to 12·9% (12·3–13·5) in 2013 for boys and from 8·4% (8·1–8·8) to 13·4% (13·0–13·9) in girls. In adults, estimated prevalence of obesity exceeded 50% in men in Tonga and in women in Kuwait, Kiribati, Federated States of Micronesia, Libya, Qatar, Tonga, and Samoa. Since 2006, the increase in adult obesity in developed countries has slowed down.

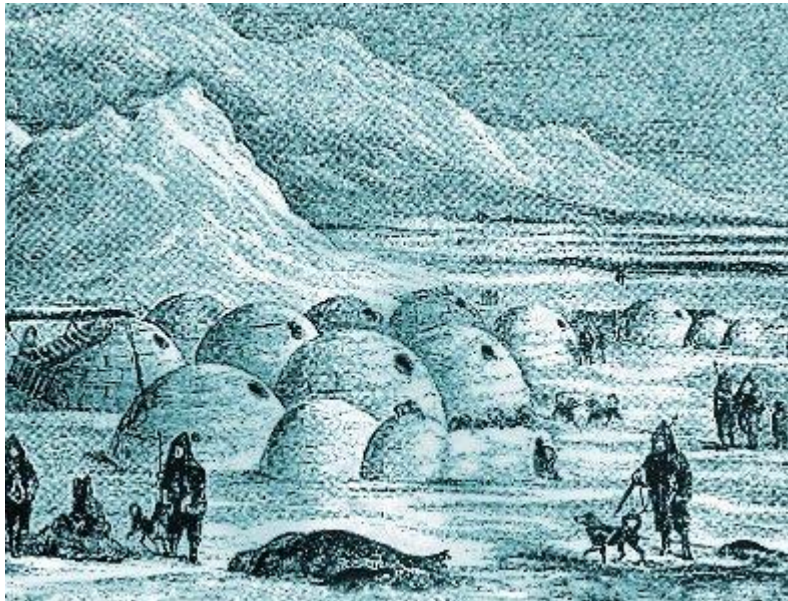
Interpretation Because of the established health risks and substantial increases in prevalence, obesity has become a major global health challenge. Not only is obesity increasing, but no national success stories have been reported in the past 33 years. Urgent global action and leadership is needed to help countries to more effectively intervene.

Funding Bill & Melinda Gates Foundation.

Ng et al. Lancet 2014

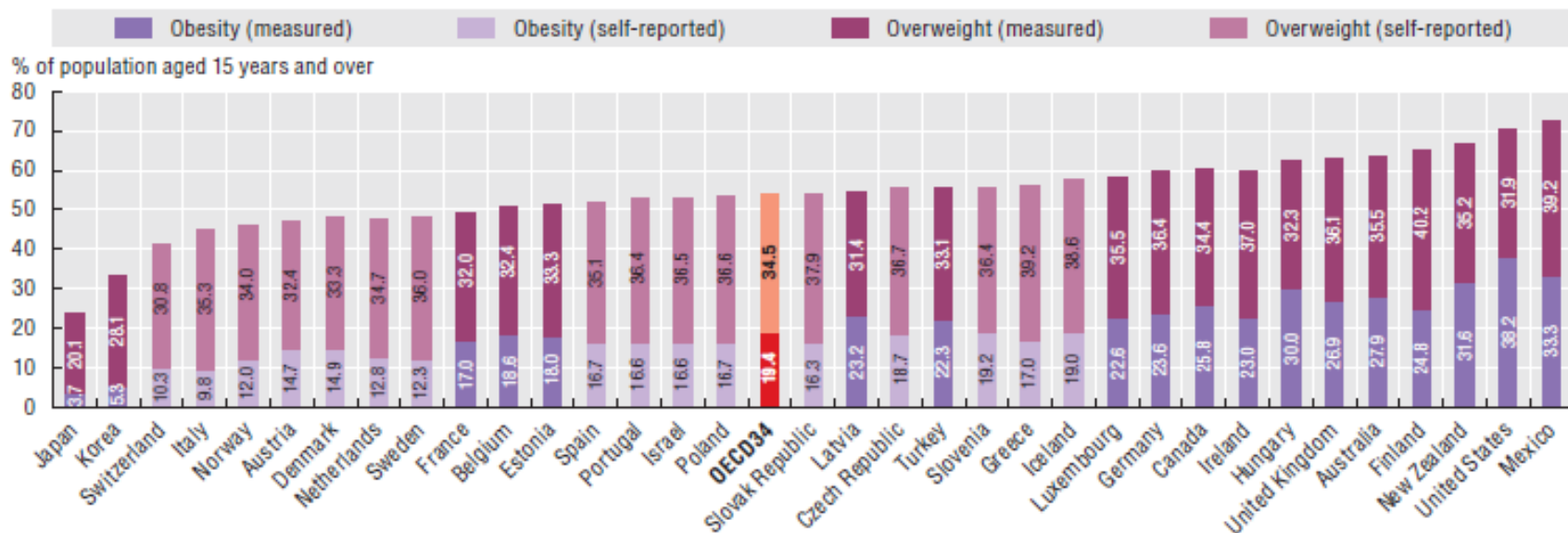
Le cause del sovrappeso e dell'obesità?

Società opulente ed obesogeniche



La situazione Italiana

4.14. Overweight including obesity among adults, 2015 (or nearest year)




Source: OECD Health Statistics 2017.

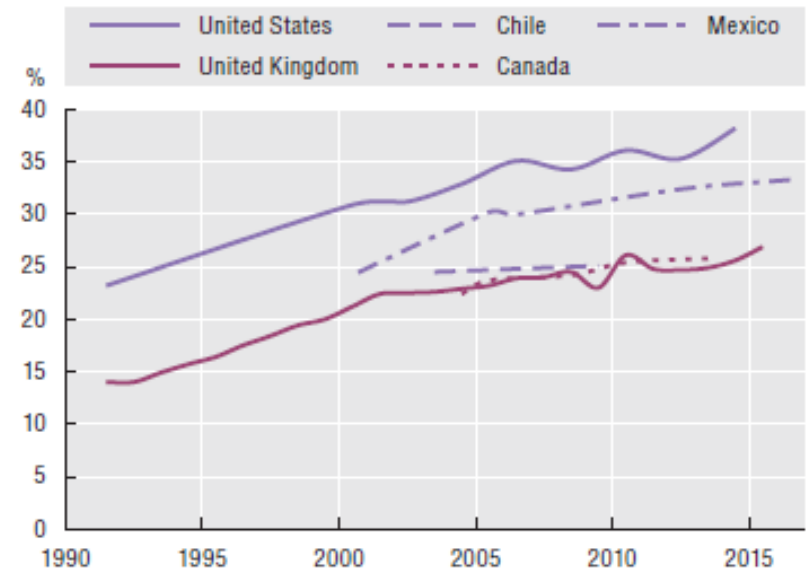
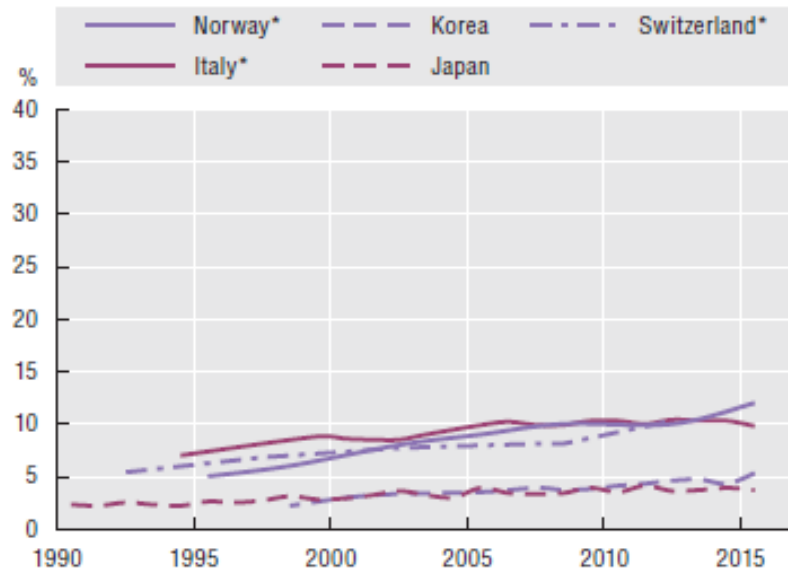
StatLink <http://dx.doi.org/10.1787/888933602956>

La situazione Italiana nel tempo

Source: OECD Health Statistics 2017.


StatLink  <http://dx.doi.org/10.1787/888933602975>

4.16. Evolution of obesity in selected OECD countries, 1990 to 2015 (or nearest year)



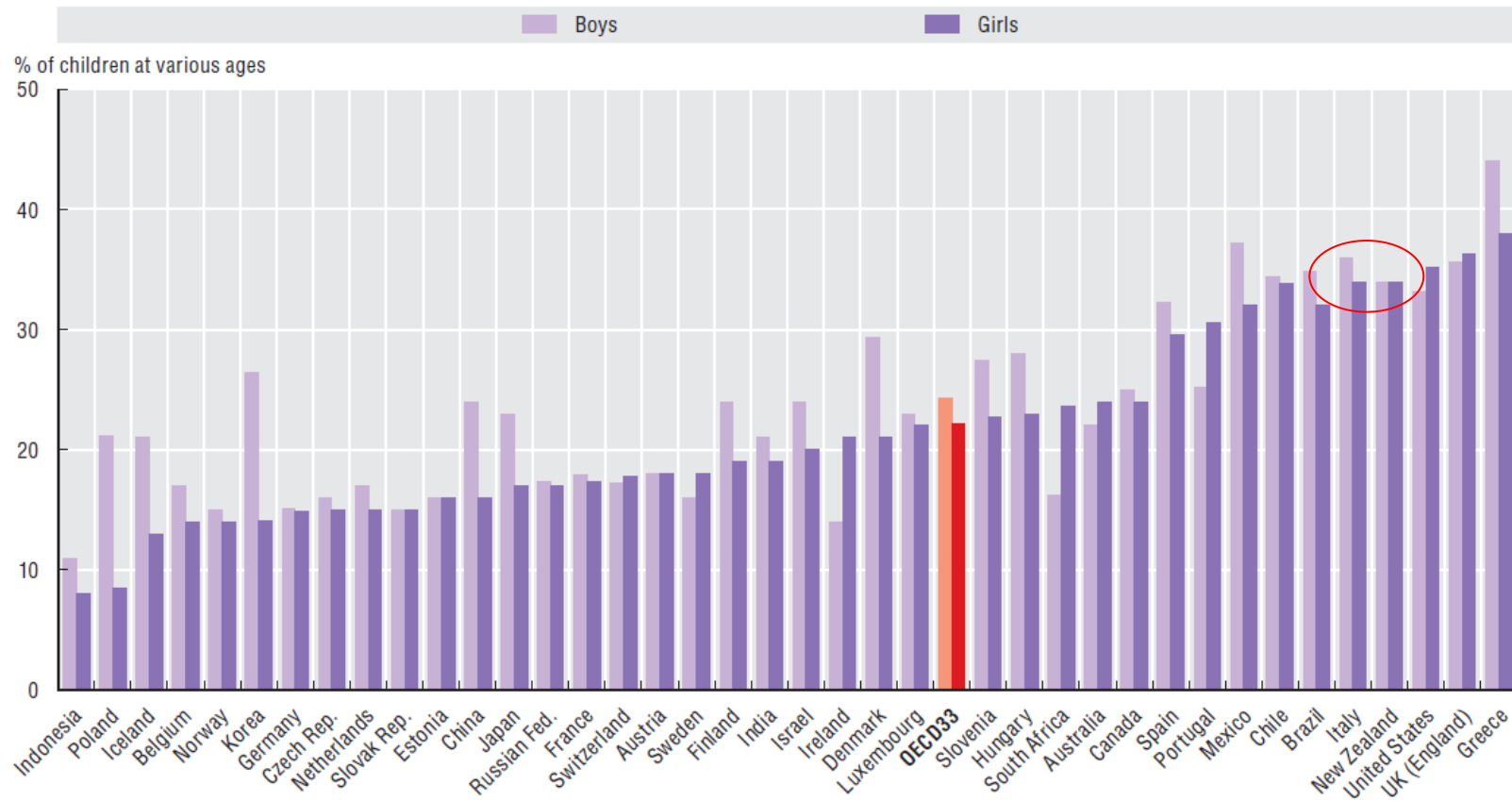
Note: Data in countries with a * were self-reported rather than measured.

Source: OECD Health Statistics 2017.


StatLink  <http://dx.doi.org/10.1787/888933602994>

Ma in Italia l'obesità tra i bambini è a livelli molto alti

4.9. Measured overweight (including obesity) among children, 2013 (or nearest year)



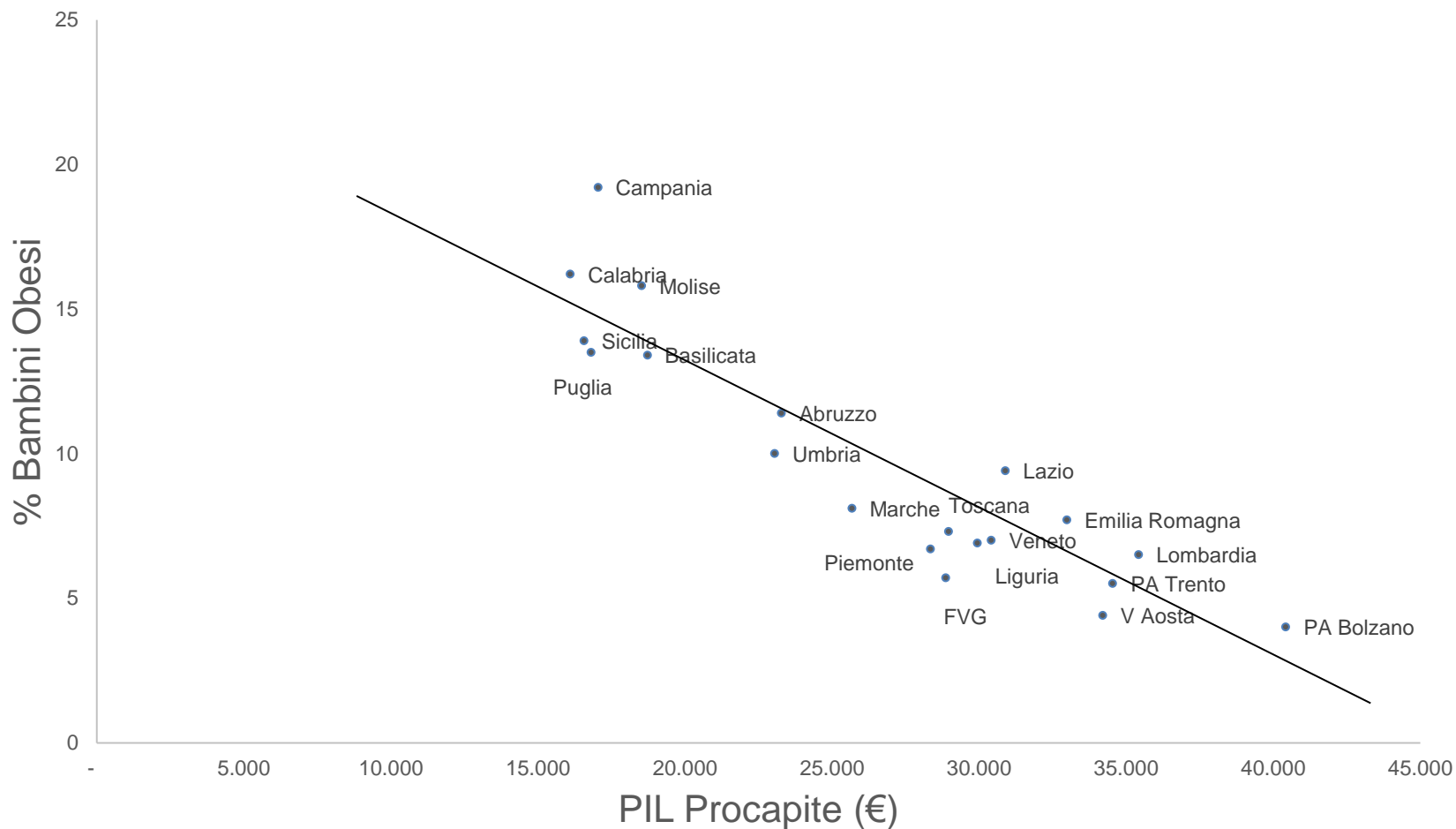
Source: World Obesity Federation (2015), KIGGS (2003-06) for Germany and KNHANES (2013) for Korea.

StatLink  <http://dx.doi.org/10.1787/888933280866>

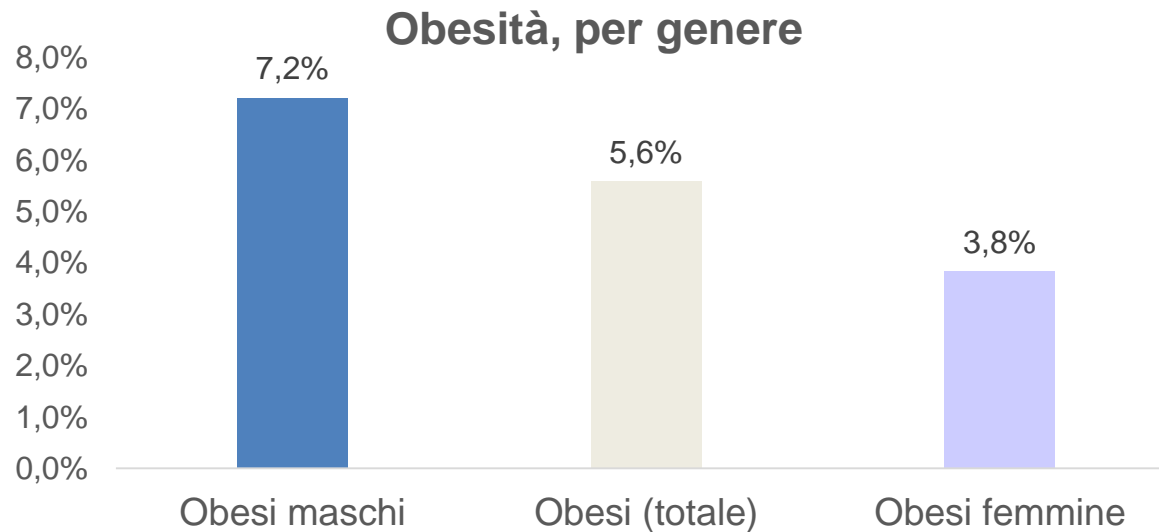
E la correlazione tra condizioni socio-economiche e obesità è molto forte

Regione	PIL Procapite	% Famiglie in povertà	% Bambini Obesi
V Aosta	34,219	6.4	4.4
Piemonte	28,358	6	6.7
Lombardia	35,438	4	6.5
PA Bolzano	40,437		4
PA Trento	34,556	6.5	5.5
Veneto	30,420	4.5	7
FVG	28,873	7.9	5.7
Liguria	29,951	7.8	6.9
Emilia Rom	32,998	4.2	7.7
Toscana	28,968	5.1	7.3
Marche	25,684	9.9	8.1
Umbria	23,058	8	10
Lazio	30,907	5.8	9.4
Abruzzo	23,285	12.7	11.4
Molise	18,537	19.3	15.8
Campania	17,053	19.4	19.2
Puglia	16,811	20.5	13.5
Basilicata	18,733	25.5	13.4
Calabria	16,106	26.9	16.2
Sicilia	16,579	25.2	13.9
Sardegna	19,296	15.1	7.3
Italia	26,656	12.9	9,8

% Bambini Obesi (9 anni) e Pil Regionale



HSBC survey: in Lombardia i bambini obesi rappresentano il 5,6% del campione: il 3,8% del totale delle femmine e il 7,2% del totale dei maschi (Fonte HSBC; 2014)



- Complessivamente, queste percentuali sono in linea con quelle rilevate dal sistema di sorveglianza Okkio alla Salute sui bambini da 6 a 9 anni. Stando all'indagine, l'incidenza dell'obesità in Lombardia sarebbe inferiore a quella media nazionale.

I principali interventi per migliorare la nutrizione

Figure 1 Classification matrix of nutrition interventions

		Who is the main target of the intervention?	
		Individual based	Population based
Who is responsible for implementation and funding of the intervention?	Health-care sector	<ul style="list-style-type: none"> - Individual counseling on diet and nutrition, and lifestyle behaviors - Prescription of medical foods - Management of moderate and severe acute malnutrition - Nutritional care & support for people living with specific conditions (e.g. HIV or TB) - Micronutrient supplementation 	<ul style="list-style-type: none"> - Media campaigns on healthy diet and nutrition - Nutrition related standards and dietary guidelines - Worksite, school or community based programmes on diet, nutrition and lifestyle behavior
	Multiple public sectors / economy at large		<ul style="list-style-type: none"> - Controls on advertising - Reformulation of foods and beverages - Fiscal policies (taxes and subsidies) - Nutrition labeling - Food fortification - Worksite, school or community based programmes on diet, nutrition and lifestyle behavior

Source:
Fattore & Federici

I principali interventi per migliorare la nutrizione

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Source:
Fattore & Federici

Meta-analyses

A systematic review of the cost and cost effectiveness of using standard oral nutritional supplements in the hospital setting

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SUMMARY

Background & aims: There is limited information about the economic impact of nutritional support despite its known clinical benefits. This systematic review examined the cost and cost effectiveness of using standard (non-disease specific) oral nutritional supplements (ONS) administered in the hospital setting only.

Methods: A systematic literature search of multiple databases, data synthesis and analysis were undertaken according to recommended procedures.

Results: Nine publications comprising four full text papers, two abstracts and three reports, one of which contained 11 cost analyses of controlled cohort studies, were identified. Most of these were based on retrospective analyses of randomised controlled trials designed to assess clinically relevant outcomes. The sample sizes of patients with surgical, orthopaedic and medical problems and combinations of these varied from 40 to 1.16 million. Of 14 cost analyses comparing ONS with no ONS (or routine care), 12 favoured the ONS group, and among those with quantitative data (12 studies) the mean cost saving was 12.2%. In a meta-analysis of five abdominal surgical studies in the UK, the mean net cost saving was £746 per patient (se £338; $P = 0.027$). Cost savings were typically associated with significantly improved outcomes, demonstrated through the following meta-analyses: reduced mortality (Risk ratio 0.650, $P < 0.05$; $N = 5$ studies), reduced complications (by 35% of the total; $P < 0.001$, $N = 7$ studies) and reduced length of hospital stay (by ~2 days, $P < 0.05$; $N = 5$ surgical studies) corresponding to ~13.0% reduction in hospital stay. Two studies also found ONS to be cost effective, one by avoiding development of pressure ulcers and releasing hospital beds, and the other by gaining quality adjusted life years.

Conclusion: This review suggests that standard ONS in the hospital setting produce a cost saving and are cost effective. The evidence base could be further strengthened by prospective studies in which the primary outcome measures are economic.

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Weekly Iron-Folic Acid Supplementation with Regular Deworming Is Cost-Effective in Preventing Anaemia in Women of Reproductive Age in Vietnam

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Abstract

Background: To estimate the cost and cost-effectiveness of a project administering de-worming and weekly iron-folic acid supplementation to control anaemia in women of reproductive age in Yen Bai province, Vietnam.

Methods and Findings: Cost effectiveness was evaluated using data on programmatic costs based on two surveys in 2006 and 2009 and impact on anaemia and iron status collected in 2006, 2007, and 2008. Data on initial costs for training and educational materials were obtained from the records of the National Institute of Malaria, Parasitology and Entomology and the Yen Bai Malaria Control Program. Structured questionnaires for health workers at district, commune and village level were used to collect ongoing distribution and monitoring costs, and for participants to collect transport and loss of earnings costs. The cost per woman treated (defined as consuming at least 75% of the recommended intake) was USD0.76 per annum. This estimate includes financial costs (for supplies, training), and costs of health care workers' time. Prevalence of anaemia fell from 38% at baseline, to 20% after 12 months. Thus, the cost-effectiveness of the project is assessed at USD 4.24 per anaemia case prevented per year. Based on estimated productivity gains for adult women, the benefit:cost ratio is 6.7:1. Cost of the supplements and anthelmintics was 47% of the total, while costs of training, monitoring, and health workers' time accounted for 53%.

Conclusion: The study shows that weekly iron-folic acid supplementation and regular de-worming is a low-cost and cost-effective intervention and would be appropriate for population-based introduction in settings with a high prevalence of anaemia and iron deficiency and low malaria infection rates.

Effectiveness of a childhood obesity prevention programme delivered through schools, targeting 6 and 7 year olds: cluster randomised controlled trial (WAVES study)

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ABSTRACT

OBJECTIVE

To assess the effectiveness of a school and family based healthy lifestyle programme (WAVES intervention) compared with usual practice, in preventing childhood obesity.

DESIGN

Cluster randomised controlled trial.

SETTING

UK primary schools from the West Midlands.

PARTICIPANTS

200 schools were randomly selected from all state run primary schools within 35 miles of the study centre (n=980), oversampling those with high minority ethnic populations. These schools were randomly ordered and sequentially invited to participate. 144 eligible schools were approached to achieve the target recruitment of 54 schools. After baseline measurements 1467 year 1 pupils aged 5 and 6 years (control: 28 schools, 778 pupils) were randomised, using a blocked balancing algorithm. 53 schools remained in the trial and data on 1287 (87.7%) and 1169 (79.7%) pupils were available at first follow-up (15 month) and second follow-up (30 month), respectively.

INTERVENTIONS

The 12 month intervention encouraged healthy eating and physical activity, including a daily additional 30 minute school time physical activity opportunity, a six week interactive skill based programme in conjunction with Aston Villa football club, signposting of local family physical activity opportunities through mail-outs every six months, and termly school led family workshops on healthy cooking skills.

OUTCOME MEASURES

The protocol defined primary outcomes, assessed blind to allocation, were between arm difference in body mass index (BMI) z score at 15 and 30 months. Secondary outcomes were further anthropometric, dietary, physical activity, and psychological measurements, and difference in BMI z score at 39 months in a subset.

RESULTS

Data for primary outcome analyses were: baseline, 54 schools: 1392 pupils (732 controls); first follow-up (15 months post-baseline), 53 schools: 1249 pupils (675 controls); second follow-up (30 months post-baseline), 53 schools: 1145 pupils (621 controls). The

mean BMI z score was non-significantly lower in the intervention arm compared with the control arm at 15 months (mean difference -0.075 (95% confidence interval -0.183 to 0.033 , $P=0.18$) in the baseline adjusted models. At 30 months the mean difference was -0.027 (-0.137 to 0.083 , $P=0.63$). There was no statistically significant difference between groups for other anthropometric, dietary, physical activity, or psychological measurements (including assessment of harm).

CONCLUSIONS

The primary analyses suggest that this experiential focused intervention had no statistically significant effect on BMI z score or on preventing childhood obesity. Schools are unlikely to impact on the childhood obesity epidemic by incorporating such interventions without wider support across multiple sectors and environments.

New Cochrane Review evidence suggests that nutritional labelling on menus in restaurants and cafes may reduce our calorie intake

New evidence published in the Cochrane Library (<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009315.pub2/abstract>) shows that adding calorie labels to menus and next to food in restaurants, coffee shops, and cafeterias could reduce the calories that people consume, although the quality of evidence is low.



Eating too many calories contributes to people becoming overweight and increases the risks of heart disease, diabetes, and many cancers, which are among the leading causes of poor health and premature death.

Several studies have looked at whether putting nutritional labels on food and non-alcoholic drinks might have an impact on their purchasing or consumption, but their findings have been mixed. Now, a team of Cochrane researchers has brought together the results of studies evaluating the effects of nutritional labels on purchasing and consumption in a systematic review.

The team reviewed the evidence to establish whether, and by how much, nutritional labels on food or non-alcoholic drinks affect the amount of food or drink people choose, buy, eat, or drink. They considered studies in which the labels had to include information on the nutritional or calorie content of the food or drink. They excluded those including only logos (e.g. ticks or stars) or interpretative colours (e.g. 'traffic light' labelling) to indicate healthier and unhealthier foods. In total, the researchers included evidence from 28 studies, of which 11 assessed the impact of nutritional labelling on purchasing and 17 assessed the impact of labelling on consumption.

The team combined results from three studies where calorie labels were added to menus or put next to food in restaurants, coffee shops, and cafeterias. For a typical lunch with an intake of 600 calories, such as a slice of pizza and a soft drink, labelling may reduce the energy content of food purchased by about 8% (48 calories). The authors judged the studies to have potential flaws that could have biased the results.

Combining results from eight studies carried out in artificial or laboratory settings could not show with certainty whether adding labels would have an impact on calories consumed. However, when the studies with potential flaws in their methods were removed, the three remaining studies showed that such labels could reduce calories consumed by about 12% per meal. The team noted that there was still some uncertainty around this effect and that further well-conducted studies are needed to establish the size of the effect with more precision.

Alimentazione e salute

- Conoscenze scientifiche sulla nutrizione molto limitate
 - Rispetto alle “tecnologie” manca un sistema regolatorio e manca un sistema di incentivi
- Ancora più limitate le nostre conoscenze sulle determinanti delle nostre abitudini alimentari e del modo con cui modificarle
 - *Downstream interventions* (comportamentali)
 - *Upstream interventions* (di contesto e favorenti modifiche comportamentali)
- Ambiente socio-economico “obesogenico” (cercare di essere più radicali?)

Come promuovere politiche favorenti una nutrizione sana

1. Mettere al centro delle politiche di prevenzione gli stili alimentari e l'esercizio fisico (con particolare attenzione ai bambini)
2. Riformulare l'approccio al cibo e alla salubrità dell'alimentazione
3. Promuovere politiche nutrizionali nelle istituzioni (ospedali, ambulatori medici, RSA, scuole, mense)
4. Disegnare e sperimentare gli interventi
5. Contrastare le determinanti sociali la mal e sovra nutrizione

1. Mettere al centro delle politiche di prevenzione gli stili alimentari e l'esercizio fisico (con particolare attenzione ai bambini)

- La sovra-nutrizione (e malnutrizione) è sottovalutata
 - Scarsa consapevolezza
 - Poco presente nei Piani sanitari (anche di prevenzione)
 - Big Food lobbying
- Timido tentativo nel 2016 (O.d.G al Senato); nuovo recente tentativo (posizioni sostanzialmente condivise tra minoranza e maggioranza)
- L'obesità infantile è segnale d'indebolimento del nostro "sistema salute" (scarsa attenzione alla prevenzione e alla promozione di stili di vita)
- Rischio di medicalizzazione della prevenzione (vaccini, screening, check-up)

2. Riformulare l'approccio al cibo e alla salubrità dell'alimentazione

No one sits down to eat a plate of nutrients! Rather, when people sit down for a meal, they are seeking physical in addition to emotional and psychological nourishment – comfort, pleasure, love and community

(Block, 2011)

2. Riformulare l'approccio al cibo e alla «salubrità» dell'alimentazione

From Nutrients to Nurturance: A Conceptual Introduction to Food Well-Being

Lauren G. Block, Sonya A. Grier, Terry L. Childers, Brennan Davis, Jane E.J. Ebert, Shiriki Kumanyika, Russell N. Laczniak, Jane E. Machin, Carol M. Motley, Laura Peracchio, Simone Pettigrew, Maura Scott, and Mirjam N.G. van Ginkel Bieshaar

The authors propose a restructuring of the “food as health” paradigm to “food as well-being.” This requires shifting from an emphasis on restraint and restrictions to a more positive, holistic understanding of the role of food in overall well-being. The authors propose the concept of food well-being (FWB), defined as a positive psychological, physical, emotional, and social relationship with food at both individual and societal levels. The authors define and explain the five primary domains of FWB: food socialization, food literacy, food marketing, food availability, and food policy. The FWB framework employs a richer definition of food and highlights the need for research that bridges other disciplines and paradigms outside and within marketing. Further research should develop and refine the understanding of each domain with the ultimate goal of moving the field toward this embodiment of food as well-being.

3. Promuovere politiche nutrizionali nelle istituzioni (ospedali, ambulatori medici, RSA, scuole, mense)

- Attenzione alla nutrizione come componente del processo sanitario-assistenziale (supporto terapeutico)
- Istituzioni come luoghi dove sperimentare ed apprendere per promuovere comportamenti più salubri («educazione» del paziente)
- Alimentazione e qualità della vita dei pazienti (non dimenticare mai che «mangiare» è una fonte di gratificazione importantissima)

4. Sperimentare e valutare

- Le evidenze sull'efficacia degli interventi nutrizionali e sovrappeso sono molto limitate
- Manca il business-model di Farma, Medical Devices e Vaccini
- Necessità di risorse terze (pubbliche e non-profit) per sperimentare e valutare gli interventi
- Valutazione continua e sistematica

5. Contrastare le determinanti sociali fondamentali

- Ridurre le diseguaglianze economico-sociali
- Promuovere l'universalità dell'acquisizione delle capacità di gestire la propria vita (le capacità fondamentali per controllare la propria vita e orientarla verso le proprie aspirazioni) (Amartya Sen)
- Usare finalmente la straordinaria ricchezza che siamo in grado di produrre per trasformarla in benessere condiviso

Il Rapporto ISTAT 2018: Un Paese dove aumenta la disuguaglianza (anche finita la crisi economica)



**RAPPORTO
ANNUALE 2018**
La situazione del Paese

Tavola 1.5 Indicatori del Bes nel Documento di economia e finanza - Anni 2008-2017

NUMERO INDICATORI	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
1 Reddito medio disponibile aggiustato pro capite (in euro)	22.154	21.665	21.576	21.886	21.224	21.179	21.245	21.525	21.836	22.226
2 Indice di disuguaglianza del reddito disponibile (a)	5,3	5,4	5,7	5,6	5,8	5,8	5,8	6,3	6,3 (b)	6,4 (b)
3 Indice di povertà assoluta (valori percentuali)	3,6	3,9	4,2	4,4	5,9	7,3	6,8	7,6	7,9	8,3 (c)
4 Speranza di vita in buona salute alla nascita (in anni)	-	56,4	57,7	58,2	58,5	58,2	58,2	58,3	58,8	58,5 (c)
5 Eccesso di peso (valori percentuali)	45,3	46,2	45,7	45,4	45,3	45,0	45,5	44,1	44,8	44,8

Grazie