Health[1]

The health topic, with the spread of the SARS-CoV-2 pandemic, has dominated the international scene in the last two years, mobilising huge human and financial resources to avert the serious risks of the loss of important shares of the population, especially the fragile one, the collapse of health systems and the worsening of a socio-economic crisis of enormous magnitude.

Italy, accustomed in recent decades to a progressive consolidation of high levels of longevity, has been among the hardest hit, also in view of the greater demographic weight of the elderly compared to other European countries.

In 2020, the first year of the pandemic, mortality was particularly high among the population aged 80 years and over, who are often in a frail condition, and was particularly evident in northern regions. In 2021, mortality among the elderly was much lower than in 2020, due to the high vaccination coverage achieved in this population group, while it increased slightly among men aged 0-49 and women aged 50-64. Furthermore, in 2021, the map of contagion changed, with the impact affecting the whole country, albeit higher in the South and Islands.

Excess mortality led to a reduction in life expectancy at birth of more than 1 year nationwide in 2020, but estimated data show a hint of recovery for 2021 with a value of 82.4 years.

Despite the decline in expected life years in 2020, the healthy life expectancy at birth indicator improved unexpectedly, with a gain of 2.4 years compared to 2019, due to an increase in the share of people who, in the context of the pandemic, probably assessed their health status more favourably. In 2021, this improvement was partially absorbed, but still life expectancy in good health remained higher than pre-pandemic levels.

The two pandemic years put a strain on the psychological well-being of the population. In particular, a deterioration in mental well-being was observed in 2021, especially among 14-19-year-olds.

The proportion of the elderly aged 75 years and over suffering from severe limitations or multi-chronicity conditions continued to decline, although levels remained high, affecting almost half of the population in this age group in 2020-2021.

With regard to lifestyles, in both 2020 and 2021, the indicator monitoring sedentariness showed a further improvement in line with the trend recorded in recent years. However, the decrease did not affect the very young 14-19-year-olds for whom there was a significant increase in the proportion of sedentary people. Excess body weight among the adult population aged 18 years and over decreased in 2021 compared to 2020, but the decrease only affected the proportion of people in an overweight condition, while the proportion of people in an obese condition increased slightly but steadily in both 2020 and 2021.

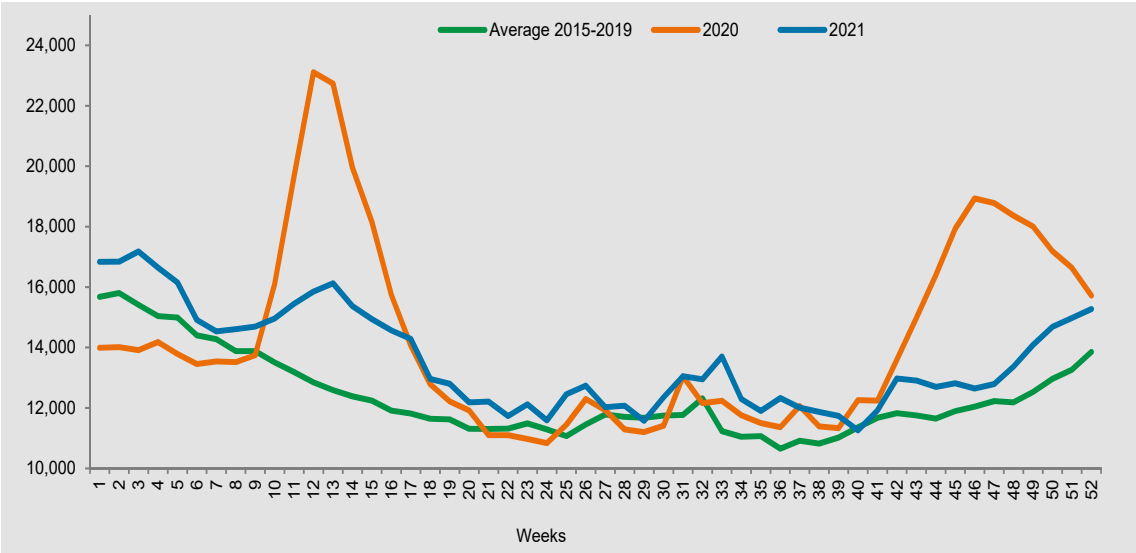
Between 2020 and 2021, the proportion of smokers remained stable, while, with regard to the proportion of people with risky alcohol consumption, an increase was observed in 2020 and, subsequently, in 2021.This is a decrease that concerned both habitual excess consumption (back to 2019 levels) and binge drinking.

1 This chapter was edited by Emanuela Bologna, with contributions from: Marco Battaglini, Silvia Bruzzone, Gianni Corsetti, Lidia Gargiulo, Laura Iannucci, Simone Navarra, Marilena Pappagallo, Silvia Simeoni, Alessandra Tinto.

In the second year of the pandemic, excess mortality drops but spreads throughout the territory

On 21 February 2020, the ISS confirmed the first case of COVID-19 positivity diagnosed at the Sacco Hospital in Milano; since then, until 31 December 2021, there have been more than 6.4 million positive cases reported, and deaths from COVID-19 in the same period were about 137,000 (78,000 in 2020, 59,000 in 2021).
In the transition between 2020 and 2021, mortality in the age group of the over-70s and in the 65-74 age group was greatly reduced, thanks to the high vaccination coverage achieved among these individuals, while mortality has increased slightly among men in the 0-49 age group and among women in the 50-64 age group. The year 2021 may be remembered as the year that saw the largest vaccination campaign in Italian history; by the end of the year, more than 109 million doses of vaccine for the prevention of the SARS-CoV-2 infection had been administered, with a total of almost 47 million people having received at least one dose of vaccine (first dose), accounting for 81.0% of the population aged 5 years or older.
One approach to measuring the impact of the COVID-19 epidemic on mortality is to count excess deaths for all causes, i.e. how many more deaths (from all causes) there were in the country than in previous years. Excess mortality can provide an indication of the overall impact of the epidemic, not only by taking into account deaths directly attributed to COVID-19 through integrated COVID-19 surveillance, but also those that may have occurred without a microbiological diagnosis or indirectly related, such as deaths caused by delayed or missed treatment due to an overburdened healthcare system. The excess mortality has been estimated by comparing, for the same period, the data for 2020 and 2021 with the average number of deaths for the five-year period 2015-2019. Thereby, implicitly assuming that the spread of the epidemic will produce an increase in deaths even if this is not directly attributable to the number of positive cases that died.
In 2021, the total number of deaths from all causes was down comparing to the previous

Figure 1. Weekly trend of deaths from all causes. Years 2020, 2021 and average 2015-2019. Absolute values



Source: Istat, Integrated Municipal Daily Mortality Database

year (Figure 1 and Table 1) but still remained at a very high level: 709,035 deaths, 37 thousand fewer than in 2020 (-5.0%), but 63 thousand more than the 2015-2019 average (+9.8%).
Compared to 2020, the excess mortality was no longer concentrated mainly in the North but spread throughout the territory, being highest in the South and Islands. On the other hand, the decrease compared to 2020 was due to the decrease in deaths observed in the North, which had been the area most affected by the pandemic, especially in the first wave of March-April 2020. The central and southern areas, on the contrary, recorded a greater increase in excess mortality in 2021 than in 2020, as they were affected by the pandemic mainly from October 2020, with the start of the second wave.

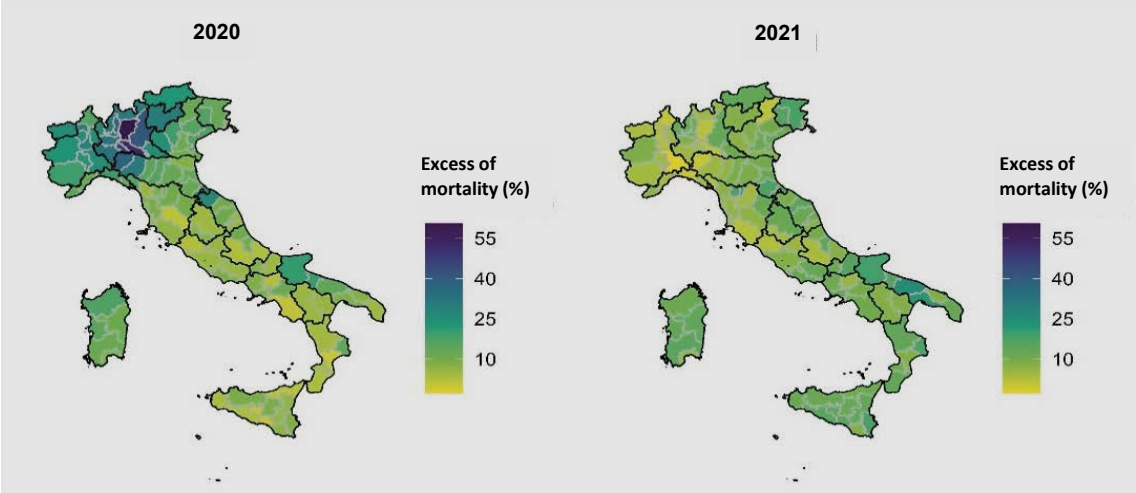
Table 1. Deaths by geographic area. Year 2021. Absolute values and percentage difference compared to 2020 and the 2015-2019 average

Geographic areas	Average 2015-2019	2020	2021	Percentage difference 2021vs2015-2019	Percentage difference 2021vs2020
North	301,885	376,181	326,534	8.2	-13.2
Centre	131,647	141,550	143,024	8.6	1.0
South and Islands	212,087	228,415	239,477	12.9	4.8
Italy	**645,620**	**746,146**	**709,035**	**9.8**	**-5.0**

Source: Istat. Integrated municipal daily mortality database

Thus, it can be said that the geography of mortality changed considerably between 2020 and 2021, as a result of the change in the spread of the virus and the progression of the vaccination campaign. These dynamics had differential effects on overall mortality, which decreased, but only due to the reduction in the northern regions. By contrast, all regions in Southern Italy, except Sardegna, saw a slight increase in mortality in 2021. Aereas such as those of Bergamo or Cremona saw their excess mortality in 2020 fall by more than 50% to just over 2%. In contrast, most central and southern provinces saw an increase in excess mortality in 2021 (Figure 2).

Figure 2. Provincial distribution of excess mortality in Italy. Years 2020 and 2021

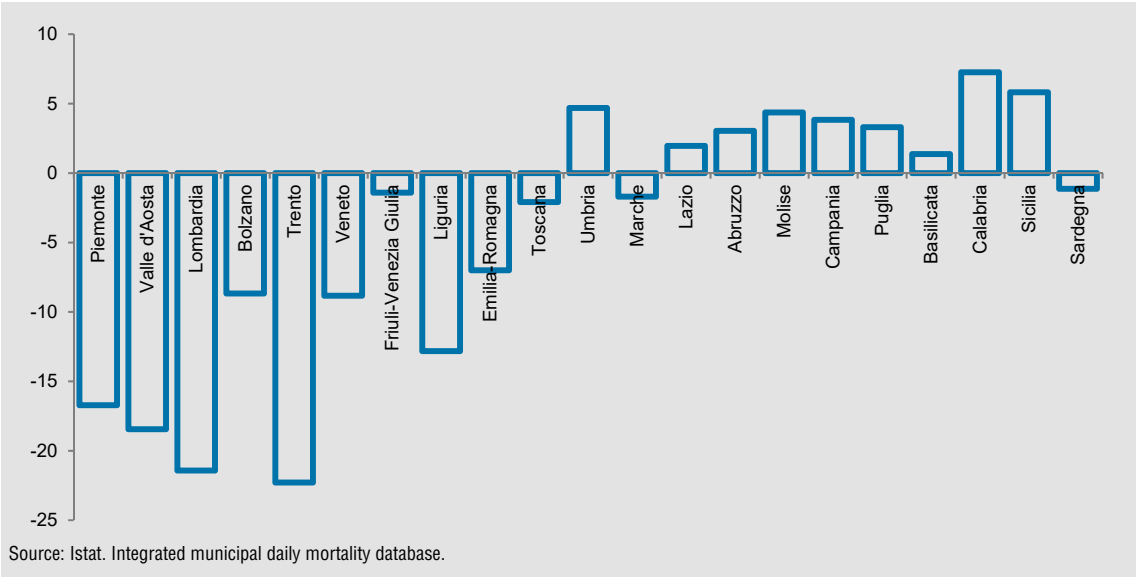


Source: Istat. Integrated municipal daily mortality database.

72% of the excess mortality was due to deaths of people aged 80 and over

Considering the age groups, the largest contribution to the excess of deaths in 2021, compared to the average of the years 2015-2019, was due to the increase in deaths in the population aged 80 and over, which explains the 72% of the overall excess mortality; a total of 455,170 people in this age group died (about 46,000 more than the average for the five-year period 15-19). The increase in mortality in the 65-79 age group explains a further 21% of the excess mortality; in absolute terms, the increase for this age group, compared to the average figure for the years 2015-2019, was more than 13 thousand deaths (for a total of 177,937 deaths in 2021).
However, it was precisely in the age group most affected by mortality in 2020 that the biggest drop in deaths was observed when comparing 2021 with 2020: over 37,000 fewer deaths in the age group 65 and over in the last year. On the contrary, in the population under 65 years of age deaths increase over the previous year, albeit by a very small amount (+745).
In the northern regions, particularly in Lombardia and the autonomous province of Trento, deaths among population aged 80 and over in 2021 fell by more than 20% compared with 2020. A more moderate decrease was also observed in the same age group in Marche and Sardegna, regions in the macro-areas of Central and Southern Italy affected by the first wave of the pandemic in 2020 (Figure 3). In the rest of Italy, however, the increase in deaths affected all age groups.

Figure 3. Percentage variations in deaths of the age group 80 years and over by region. Year 2021. Percentage variations compared to 2020

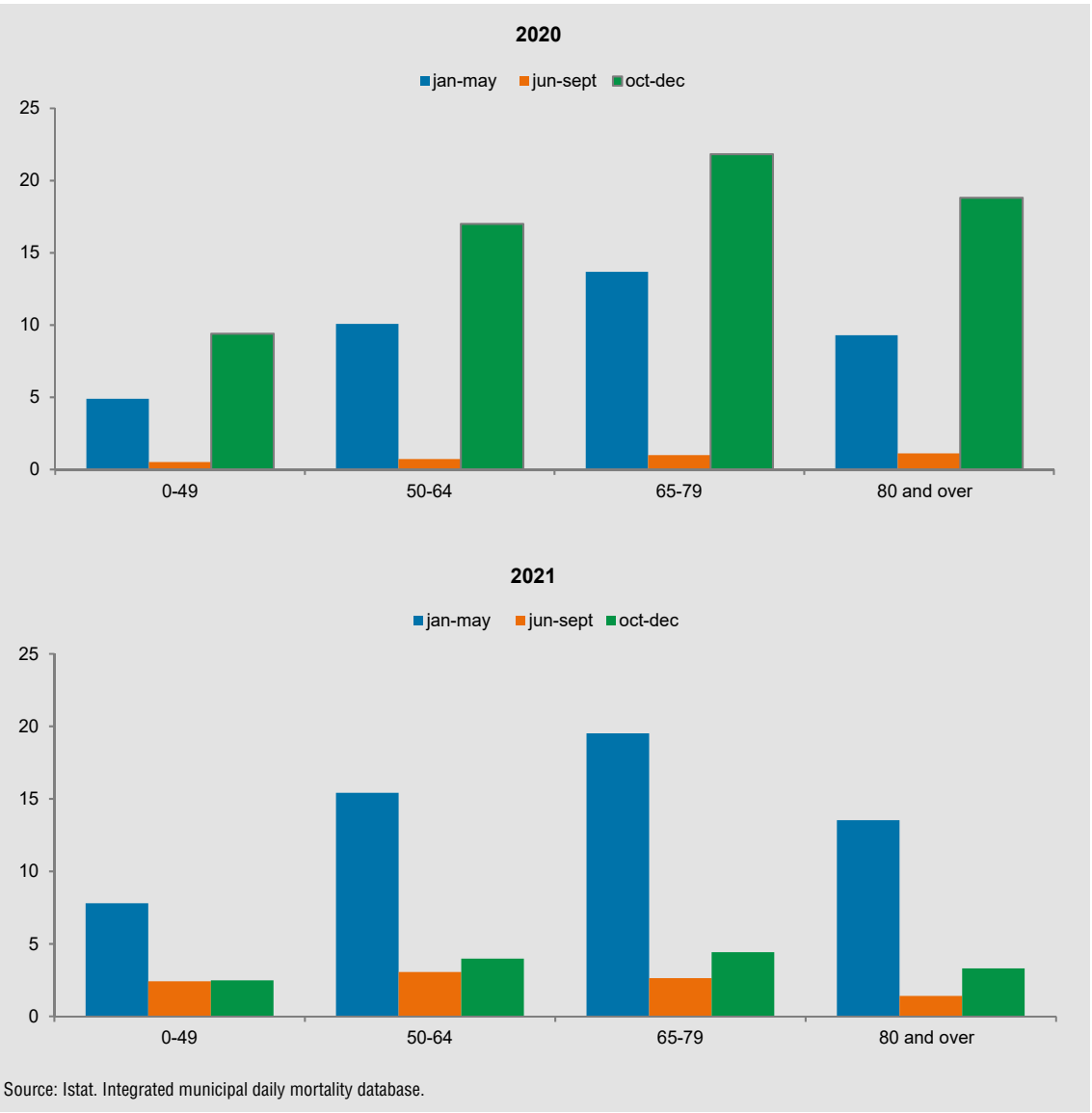


Source: Istat. Integrated municipal daily mortality database.

The deaths reported to integrated surveillance considered to be related to COVID-19 in 2021 amounted to 59,000 and represented 8.3% of total deaths from all causes, a proportion that is down from the previous year when there were more than 77,000, 10.3% of the total. The North remains the area with the highest proportion of COVID-19 deaths out of total deaths, with an average value for the area for 2021 of 9%. However, compared to the previous year there was a decrease in this percentage: almost all northern regions had values above 10% in 2020, with peaks of over 20% in Valle d'Aosta. In contrast, in the central

and southern regions, the share increased in 2021, compared to 2020, from 6.9% to 7.7% in the Centre and from 5.3% to 7.6% in the South.
In 2020, on a national average the 65-79 age group had the highest share of COVID deaths on total deaths (12.6%), followed by the oldest age group (9.8%) and the 50-64 age group (9.3%). In 2021, the 65-79 age group still had the highest percentage (11.0%), while the 50-64 age group (8.9%) outnumbered the 80+ age group (7.3%), reflecting what happened in the Centre and especially in the South and Islands.
The impact of COVID-19 deaths on total mortality in the year 2021, for all age groups, was mainly due to the January-May period when the impact of vaccination was still limited, while in 2020 it was evident that the second phase (October-December) had the highest proportion of COVID-19 deaths out of total deaths. However, it should be noted that in the first two months of 2020 the impact of the COVID-19 epidemic still did not exist (Figure 4).

Figure 4. Ratio of COVID-19 deaths out of total deaths by age and period, Italy. Years 2020 and 2021. Percentages

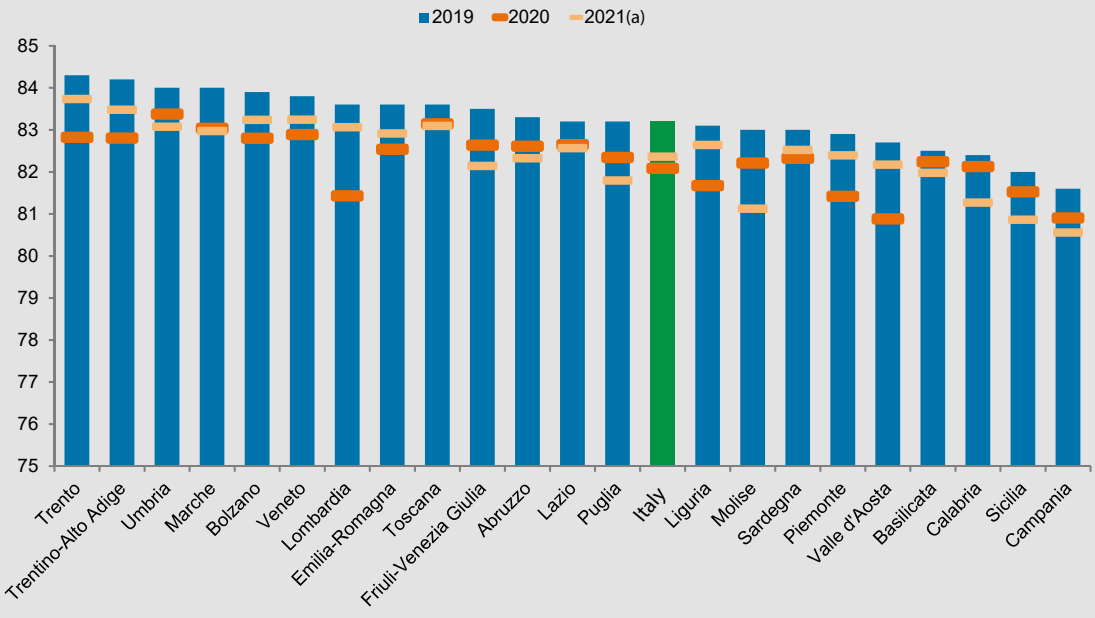


Source: Istat. Integrated municipal daily mortality database.

Slight recovery in life expectancy at birth in 2021, after falling by more than 1 year in 2020

Excess mortality caused life expectancy at birth to fall by more than 1 year nationwide in 2020 (from 83.2 in 2019 to 82.1 years in 2020), but provisional estimates for 2021 suggested a hint of recovery with an estimated figure of 82.4 years. The start of this moderate recovery was due to the fact that the excess mortality, although also recorded in Italy in 2021 compared to the five-year period 2015-2019, was less severe than 2020 excess mortality. This was thanks to the massive vaccination campaign - which, however, began to produce positive effects after a certain threshold of coverage, i.e. in late spring - and to the improvement in treatment, despite the wider spread of the epidemic and its variants.
In the North-west, almost 2 years of expected life expectancy at birth were lost in 2020 alone (-1.9 years) compared to 2019, and this affected all regions of this macro-area, peaking in Lombardia at -2.2 years. In the North-east, the reduction was in line with the Italian average (-1.1 years), but higher in the autonomous province of Trento (-1.5 years). In the Centre and the Southern Italy, the decrease was smaller (-0.6 years), with a spread ranging from -0.9 years for Puglia to -0.3 for Calabria and Basilicata. The regional ranking was, thus, overturned in 2020: Lombardia plummeted from seventh place in 2019 to fourth to last, while Campania, always at the bottom of the regional ranking for decades, became second to last, giving way to Valle d'Aosta (Figure 5). However, the estimates for 2021 showed important recoveries, especially in the worst affected region, Lombardia, and in other regions of the North-west, as well as in the autonomous provinces of Trento and Bolzano. On the other hand, the values for Friuli-Venezia Giulia and for some regions of Southern Italy, in particular Molise, Calabria, Puglia and Sicilia, were estimated to worsen still further in 2021, compared to both 2020 and 2019, losing more than 1 year of average life expectancy compared to 2019 (from 1.1 to 1.4 if not 2 in the case of Molise).

Figure 5. Life expectancy at birth by region. Years 2019, 2020 and 2021 (a). In years



Source: Istat, Mortality tables of the Italian population.
(a) The data for 2021 is a provisional estimate.

As is well known, the pandemic crisis has claimed more victims among men than women. Men, who had reached a record 81.1 years of life expectancy at birth in 2019, lost 1.3 years in 2020, eroding the acquired longevity progress and falling back to the 2012 figure. Women, who also peaked at 85.4 years in 2019, fell back to the 2015 figure of 84.5 years, losing 0.9 years. For 2021, estimates forecast a recovery of about 3 months for men and 3 for women. But at the territorial level, the net recovery in 2021 in the North of the country (with the exception of a few regions) for both men and women was contrasted by the further decrease in life expectancy at birth in the South and Islands for both genders; thus, the geographical differences between the North and the South of the country increased (they were 1.1 years in 2019 for men and 1.2 for women, increasing for both to -1.6 years).

In 2021, the improvement in healthy life expectancy observed in 2020 decreased among women

Despite the clear decline in expected life years, the indicator of healthy life expectancy at birth improved in 2020 due to an increase in the prevalence of perceived good health recorded in the context of the pandemic. Analyses conducted on the trend in perceived health in 2020, which we recall summarises the broader concept of health as defined by the WHO[2], have shown the strong sensitivity of this indicator in the different contexts of health emergencies caused by the pandemic. In fact, this was the case in many other European countries, where increases in perceived good health were mainly observed[3], although there were exceptions for a smaller number of countries, for which a decrease was recorded instead. The share of people in Italy who declared that they feel well or very well reached 72.0% in 2020, an increase of 3 percentage points in just one year, while the share of those who reported more neutral evaluations - neither positive nor negative - regarding their health decreased. The increases are widespread and concern both genders, although they are far more significant among adults aged 35-54[4] (+5 percentage points), particularly among women.
In 2021, this marked improvement in overall perceived good health declines by about 1 percentage point to 71.0%, smoothing out the exceptional increases recorded among adults. At the same time, there were increases in incidence in the older population (75 years and older), particularly among men, which were not apparent in 2020.
Indeed, the healthy life expectancy indicator, calculated in the pandemic and post-crisis years, shows a breaking point in the stability that has never been recorded before; these are exceptional years compared to the past and should be interpreted with due caution. In 2020, life expectancy in good health was estimated at 61 years, with a sudden gain of 2.4 years compared to 2019 (it was 58.6 years), so the proportion of years to be lived in good health increased to 74.3% (it was 70.4% in 2019), also due to the opposite trends of the two components of the indicator (life expectancy and prevalence of perceived good health).

2 The indicator originates from the WHO-recommended question "How is your health in general", to capture the broader concept of health, which includes the different dimensions of physical, mental and relational health, including the emotional one that reacts more in times of crisis. An extensive literature documents the relevant predictive factor of the mirror indicator "perceived poor health" due to mortality, hospitalisation, loss of self-sufficiency (See https://www4.istat.it/it/files/2015/11/Rapporto_salute_26_11_2013_01.pdf).
3 Eurostat Database: https://ec.europa.eu/eurostat/databrowser/view/hlth_silc_02/default/table?lang=en
4 See Istat, *Annual Report 2021* (https://www.istat.it/storage/rapporto-annuale/2021/Rapporto_Annuale_2021.pdf).

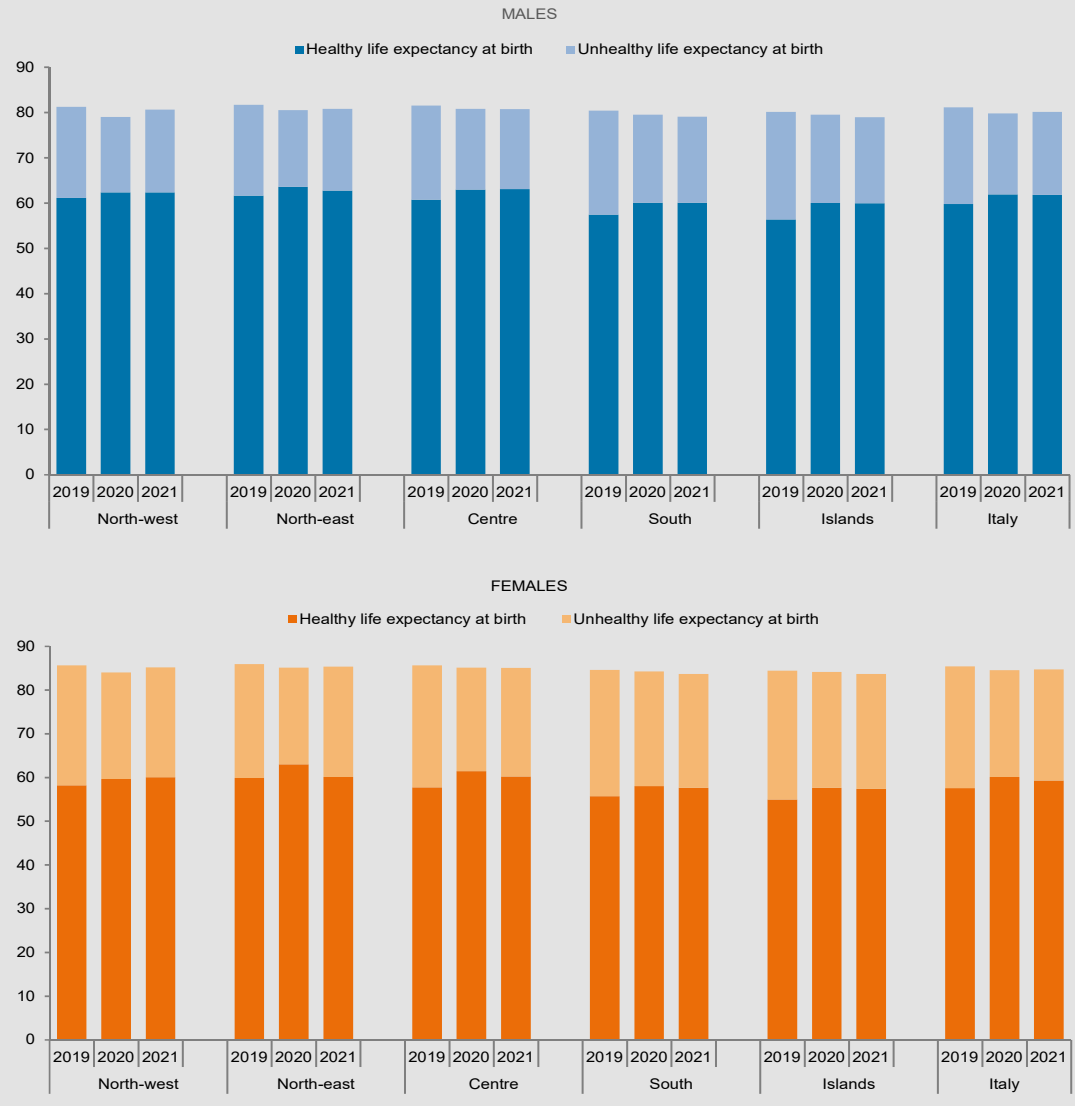
In 2021, on the contrary, the combination of these two components and the trends with respect to 2020 resulted in a slight readjustment downwards, with the value for men and women being 60.5 years, and thus a reduction of about 6 months compared to 2020.

Healthy life expectancy stable for men, falling for women

For men in Italy, the value of healthy life expectancy at birth in 2020 stood at 61.9 years (+2.1 years compared to 2019), an increase that would also be confirmed in 2021 with an estimated value of 61.8 years, compared to a life expectancy of 79.8 years in 2020 and 80.1 in 2021. For women in 2020, healthy life expectancy at birth reached 60.1 years (+2.5 years compared to 2019), but in 2021 the value was estimated at 59.3 years, i.e. down by about 10 months, compared to the average life expectancy of 84.7 years.
Comparing what happened in the various geographic areas in 2020 and 2021, compared to 2019, and differentiating by gender, the picture that emerges is further articulated (Figure 6). The epidemic waves affected the areas of the country differentially: in 2020 the excess mortality mainly affected the North, while in 2021 almost all areas were affected, but mostly the regions of the Southern Italy and the North-east.
For men in the North-east, i.e. those most affected in the first phase of the pandemic, the gain in years to be lived in good health compared to other areas of the country was the most modest in 2020 (+1.2 years), for an indicator value of 62.3 years. In 2021, although they recovered more than two-thirds of the life years lost in 2020, they only increased the number of years to be lived not in good health, given that the indicator of expected healthy years remained stable at 62.3 years, although higher than in 2019 (it was 61.1 years). On the other hand, men in the North-east, with an estimated gain of about 2 years in good health in 2020, reached 63.6 years (the highest level ever recorded), but in 2021 this value settled down by almost 1 year (62.7 years), with a recovery of life years lost of only 3 months compared to the year lost between 2020 and 2019. Nevertheless, in central Italy, men, besides having a smaller reduction in life expectancy than in the North, in both pandemic years only recovered healthy life years at the cost of unhealthy ones: in 2019 the former were equal to 60.7 out of a total of 81.5 expected life years, in 2021 (similarly to 2020) they increased to 63.1 out of a total of 80.7 years. In contrast, residents in the South and the Islands gained an average of 3 years in 2020, thus reaching 60 years of expected life expectancy in good health at birth, almost halving their gap with the Northern figure of 2019. These values are reconfirmed for 2021, but, since at the same time, more years of expected life expectancy had been lost, the years lost since 2019 relate to life expectancy at birth in poor health (almost -4 years in the South and -4.7 in the Islands compared to 2019).
Although women living in the North-west lost the most in terms of years to live in 2020 (-1.6 years) compared to other areas of the country, they gained almost as many years in good health, reaching 60 years on average in 2021, i.e. 70.5% of the years to live will be lived in good health compared to 68% in 2019. In the North-east, the highest average number of years to be lived in good health for women was confirmed in 2020 (63 years), with an estimated gain compared to 2019 of more than 3 years, despite the drop in life expectancy (-0.8 years). In 2021, however, this data was completely in line with that of 2019, at 60.1, and they are the only population group that does not record even slight increases for this indicator compared to the pre-pandemic period. On the other hand, women residing in

the Centre confirmed the increases already recorded in 2020 in healthy life expectancy for 2021, reaching 60.2 years (compared with 57.7 in 2019), for a share of 70.8% of the years to be lived in good health (it was 67.4% in 2019). In the South and Islands, the increases recorded in 2020, although with slight readjustments in 2021, however, did not reduce the well-known geographical differences in healthy life expectancy compared to the North. Women in the South continued to lose years of life in 2021 and, just as for men in the same geographic area, they mainly lost years of life in poor health, as the share of years to be lived in good health increased compared to 2019 from 65.9% to 68.9% in 2021, when it was estimated at 57.6 years (it was 55.7 in 2019). For women from the Islands, these trends are also repeated, but in 2019 they had lower levels of healthy life expectancy (54.9 years) and thus increased the share of years to be lived in good health (from 65.1% to 68.6% in 2021).

Figure 6. Life expectancy at birth and healthy life expectancy at birth by geographic area and gender. Years 2019, 2020 and 2021 (a). In years



Source: Istat, Mortality tables of the Italian population and Survey on Aspects of Daily Life.
(a) The data for 2021 is a provisional estimate.

More moderate impact of the pandemic on life expectancy without limitations at age 65

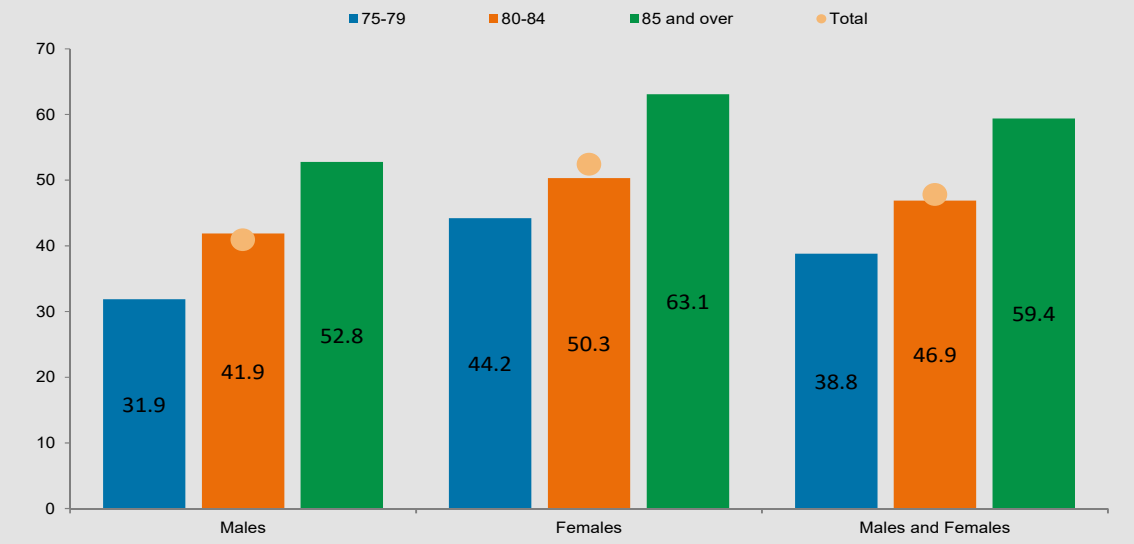
The pandemic shock seems to have had a more moderate impact on life expectancy without limitations at 65 years of age. For women, the changes are minimal, life expectancy without limitations at age 65 fell from 9.8 in 2019 to 9.7 in 2020 and to 9.6 years in 2021. For older men, the decline was greater: in 2020 compared to 2019, life expectancy without limitations fell from 10.2 to 9.5 years, although life expectancy at 65 years of age fell by 1.2 years, but the greatest reduction concerned men in the South, who lost 1 year of life expectancy without limitations at age 65, compared to a reduction in life expectancy of 0.7 years. The 2021 figure, however, showed a recovery only for elderly men in the North-west, who, in addition to recovering the years lost in 2020, gained about 6 months of life without limitations after the two years of the pandemic, the same as those who lost residents in the Islands in 2021, while in the other geographic areas the values for this indicator did not change. In particular, there is a reduction in the first year of the pandemic for elderly women in the North (-0.8 in the North-west and -0.5 in the North-east), who, unlike their male peers, were not able to recover in 2021, while the only slight increase concerned women resident on the Islands.
It will inevitably be a question of monitoring future effects in order to understand to what extent this pandemic, with its direct effects, e.g. attributable to the long-COVID, or indirect effects, e.g. due to the greater difficulty of access with the postponement of treatment, may lead to an excessive exposure to the risk of disease in future years, compromising the gains in health and years of independent life that have been achieved in these decades. If, on the contrary, the years of life lost and in better health were recovered in a short period of time, another hypothesised post-COVID scenario would emerge, namely that the impact of the pandemic had a disruptive effect, but affected mainly the most fragile population, preserving even elderly but more resilient population profiles.

Almost half of the elderly are in poor health, the percentage has been declining in recent years

The increase in life expectancy of the population, together with the decrease in the birth rate, have strongly characterised Italy in recent decades, with a significant impact on the age structure of the population. As of 1 January 2021, there were more than 7 million residents in Italy aged 75 years and over (there were about 5 million 900 thousand in 2010), corresponding to the 11.9% of the total population. The ongoing pandemic has had a strong impact on the elderly population, as the most fragile segment in terms of health conditions. In particular, in 2021 it was observed that 47.8% of the population aged 75 and over was either multi-chronic (suffering from three or more chronic diseases) or had severe limitations in the activities that people usually do. This share was higher for those living in the South and Islands (55.2% compared to 44.1% in the North and 45.2% in the Centre) and among women (52.4% compared to 40.9% among men) and reached 59.4% among people aged 85 and over (compared to 38.8% among people aged 75-79) (Figure 7).
Since 2014, there has been a reduction in the proportion of elderly people with severe limitations or in a multi-chronic condition (they were around 54% in 2013) due to the gen-

eral improvement in the health of the population, but levels among the elderly population still remain high. This reduction was higher among women (-8.4 percentage points) than among men (-2 percentage points).
Hypertension and osteoarticular problems (osteoarthritis/arthritis) were among the chronic diseases that most characterised this age group, which, alone or in conjunction with other chronic diseases, affected 1 in 2 elderly persons in this age group. This was followed by osteoporosis (30.5%), diabetes (20.8%) and certain diseases affecting the nervous system (15.9%). In this group,[5] Alzheimer's disease and senile dementia affected almost 1 in 10 elderly persons (8.3%), while Parkinson's disease affected a lower percentage at 2.9%.
The proportion of elderly people in poor health was lower among those with at least a high school diploma (32.8% among men and 42.8% among women), while it increased among those with at most a primary school diploma (44.7% among men and 56.1% among women).

Figure 7. Persons aged 75 and over with three or more chronic conditions and/or severe limitations that last for at least six months in carrying out the activities that people usually do, by gender and age group. Year 2021. Percentages



Source: Istat, Survey on Aspects of Daily Life

Mental well-being worsened among adolescents and people living in the North-west

The World Health Organisation describes mental health as an essential component of health, defining it as the state of well-being that enables an individual to realise his or her abilities, sustain normal levels of stress in daily life, and work productively, and contribute to his or

5 From 2021 onwards, in addition to the 15 chronic diseases recorded from 1993 onwards in the "Aspects of daily life" survey (diabetes, arterial hypertension, heart attack, angina pectoris or other diseases of the heart, chronic bronchitis/ emphysema/respiratory insufficiency, bronchial asthma, allergic diseases, cancer - including lymphoma or leukaemia -, gastric or duodenal ulcer, stones in the liver and gallstones, liver cirrhosis, kidney stones, osteoarthritis/arthritis, osteoporosis, nervous disorders), stroke, Parkinson's disease and Alzheimer's/dementia have also been included. These last two conditions are, as of 2021, considered within the "nervous disorders" category and contribute to the creation of the indicator of multi-chronicity and/or severe limitations, whereas up to 2020 they were not included in this category.

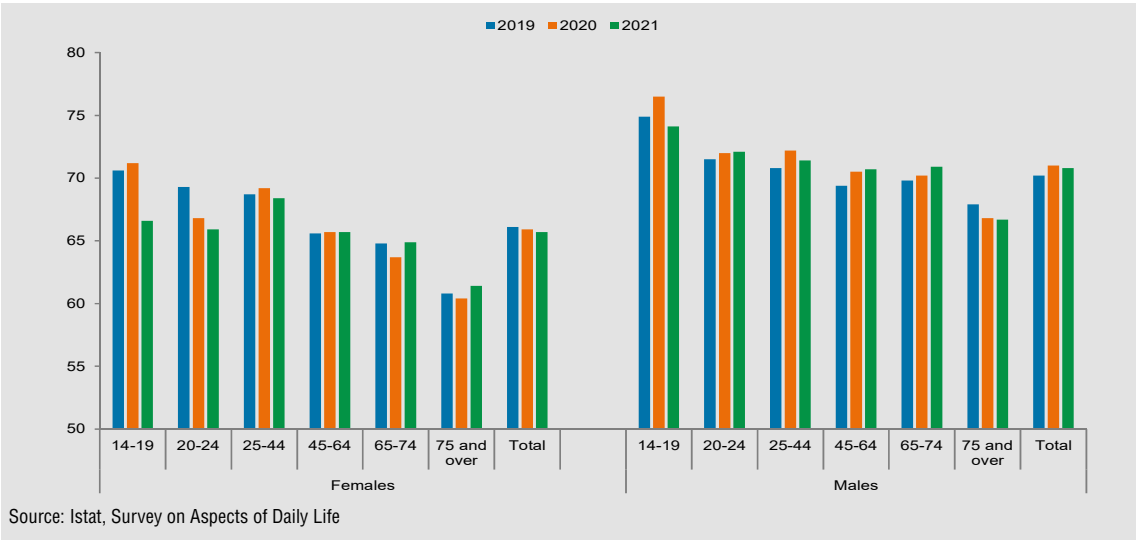
her community[6]. The analysis of the mental health index[7], although within the limits of its synthetic measurement, takes on particular relevance in the two pandemic years, in order to attempt to monitor the effects on the psychological and emotional component, which is more subject to the considerable changes in social and relational life that occurred during this period[8].

In 2021, the index assumed the value of 68.4 in Italy, and was on the whole stable compared to 2019 and 2020 (when it was 68.4 and 68.8 respectively)[9].

However, it is very useful to analyse its trend by population subgroups and by territory. In 2021, the index decreased among women, highlighting a deterioration in mental health, while it increased slightly among men, with the result that the gender gap widened further over time, from 3.7 to 4.9 points lower for women between 2019 and 2021.

Mental well-being generally deteriorates as age increases, but in 2021 the gap between younger and older people narrowed to -6.8 points when comparing the over-75s to 14-19 year-olds, the gap was -10.9 points in 2020. The narrowing of the gap depends on a deterioration in psychological well-being among young people in 2021. In fact, after an improvement in 2020, in the second year of the pandemic the mental health index dropped sharply in the 14-19 age group for both sexes, to a score of 66.6 for girls (-4.6 points compared to 2020) and 74.1 for boys (-2.4 points compared to 2020), respectively. Among women, a deterioration in mental health was also observed in the 20-24 age group (-3.4 compared to 2019), while in the other age groups substantial stability was observed, if not a slight improvement for adult men and young seniors (Figure 8).

Figure 8. Mental health index for persons aged 14 and over by gender and age groups. Years 2019, 2020 and 2021. Average scores



Source: Istat, Survey on Aspects of Daily Life

6 https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response

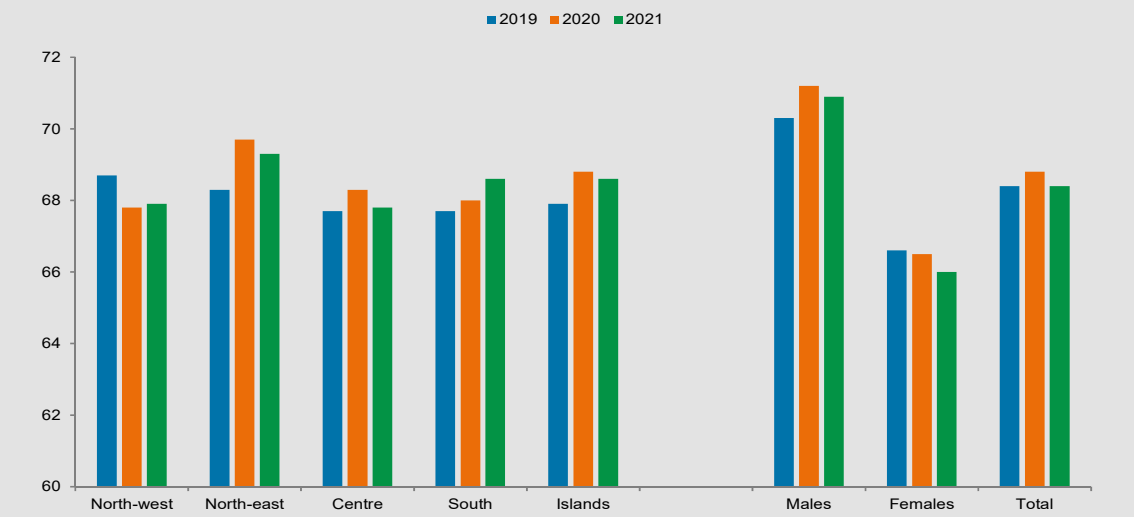
7 Among the psychometric-instruments developed at the international level, the SF-36 Mental Health Index (MH), based on the aggregation of scores by each individual in response to five specific questions, is one of the Bes indicators. The index provides a measure of individuals' psychological distress and includes states related to anxiety and depression (Keller, S.D., J.E. Ware, P.M. Bentler *et al.* 1998. "Use of structural equation modelling to test the construct validity of the SF-36 Health Survey in ten countries: Results from the IQOLA Project". *Journal of Clinical Epidemiology*. Volume 51, No. 11: 1179-1188).

8 Investigations are underway, also at international level, to identify shared tools that can help to better capture the multiple specificities of this dimension of health. See https://www.oecd.org/wise/

9 As the score increases, taking values between 0 and 100, the assessment of mental health conditions improves.

The territorial analysis showed a deterioration in psychological well-being conditions in the North-west in 2020 that also persisted in the second year of the pandemic, with the standardised index of mental health falling from 68.7 in 2019 to 67.9 in 2020-2021. The trend was different in the North-east, the Centre and the Islands, where the index improved in 2020 and then fell in 2021; finally, in the South, the index improved, although slightly, in both years (Figure 9). The decline observed in the Centre-North regions in the two pandemic years was particularly evident among the youngest: among 14 to 24-year-olds living in the North-west, the mental health score dropped from 71 points in 2019 to 66.6 in 2021.

Figure 9. Mental health index for persons aged 14 and over by geographic area. Years 2019, 2020 and 2021. Average scores



Source: Istat, Survey on Aspects of Daily Life

Avoidable mortality is reducing over time, especially among men

The avoidable mortality indicator refers to deaths of people under 75 that could be significantly reduced.
This indicator consists of two components, treatable mortality and preventable mortality, and refers to those causes of death that can be reduced through adequate and accessible health care as well as through the diffusion of healthier lifestyles in the population and the reduction of environmental risk factors. In particular, preventable mortality refers to mortality that can be avoided by effective primary prevention and public health interventions. Treatable mortality refers to those deaths that could be contained through timely and effective health care in terms of secondary prevention and appropriate health treatment[10]. In 2016[11], these types of causes accounted for the deaths of about 1 million people in Europe (equivalent to a rate of 25.4 per 10,000 inhabitants).

10 The definition of the lists of treatable and preventable causes is based on the joint OECD/Eurostat work, revised in November 2019. In this definition, the age up to which a death is considered preventable is set at 74 years to reflect current life expectancy. The list of diseases/conditions and the age limit reflect current health expectations, medical technology and knowledge, and developments in public health policy and, therefore, may be subject to change in the future.

11 The latest available data referring to the EU average is for 2016. Provisional data for 2018 are available for some countries, but the overall EU-wide figure is not available.

In 2019, the standardised avoidable mortality rate was 16.5 per 10,000 residents for Italy, placing it in a more advantageous position within the European ranking. In particular, when considering preventable mortality, the mortality rate was 10.1 per 10,000 and when considering treatable mortality 6.4 per 10,000. Compared to 2018, a reduction was observed especially in the preventable component (it was 10.5 per 10,000 in 2018), while treatable mortality, although slightly decreasing, showed more stability than in 2018 (it was 6.5 per 10,000 inhabitants).

Gender differences are considerable, with higher values of avoidable mortality among men than among women (21.7 per 10,000 inhabitants against 11.6 - Figure 10). In particular, the male disadvantage is mainly explained by the "preventable" component, i.e. that which is more closely linked to lifestyles (e.g. alcohol abuse, greater propensity to smoke, inadequate diet) and to more risky behaviour (accidental events, work activity, etc.). For preventable mortality, the value for men was, in fact, 14.9 per 10,000, and for women 5.6; for treatable mortality, the rate for men was 6.8 per 10,000, and for women 6.0.

A strong reduction in avoidable mortality has been observed over time (the standardised rate was 23.4 per 10,000 in 2005), especially in the preventable component (it was 14.7 per 10,000 in 2005). This is due to the decrease in mortality from some of the main causes: for example deaths from lung cancer fell (under 75 years of age from 18,332 in 2005 to 15,658 in 2019) and also deaths from ischaemic heart disease, which fell significantly from 2005 to 2019 (from 18,826 fell to 11,781). The decrease for these causes of death was observed especially among men, resulting in a narrowing of the gender gap.

The avoidable mortality rate among women has decreased less over time (from 15.2 per 10,000 residents in 2005 to 11.6 per 10,000 residents in 2019).

Figure 10. Standardised rates of avoidable mortality (preventable and treatable) of persons aged 0-74 years by gender. Years 2005-2019. Per 10,000 residents

Source: Istat, For deaths: Survey of deaths and causes of death. For population: Survey of municipal resident population by sex, year of birth and marital status

Different regional profiles for the two components of preventable mortality

Different regional profiles are observed with respect to the two components of avoidable (preventable and treatable) mortality. It is interesting to note that some regions have only one component that is higher than the national average and not both, indicating the need for differentiated policies across the territory.
The most critical situations are observed in Campania, followed by Calabria, Sicilia, Lazio and Piemonte, where both preventable and treatable mortality rates are higher than average.
Sardegna, Molise, Friuli-Venezia Giulia and especially Valle d'Aosta present preventable mortality rates above the national average and, conversely, treatable mortality rates below the observed average.
Puglia, Abruzzo and Basilicata, on the other hand, have treatable mortality rates above the national average and, on the contrary, preventable mortality rates below the average value.
A better picture is observed in the autonomous province of Trento followed by the autonomous province of Bolzano, Marche, Umbria, Veneto, Emilia-Romagna, Lombardia and Toscana where, for both components of preventable mortality, the values are below the general average. Finally, Liguria has values overlapping with the national average.

Infant mortality and mortality from malignant tumours among adults decreased, while mortality from dementia and diseases of the nervous system increased

The infant mortality rate in 2019 was 2.5 per 1,000 live births and was down from the figure recorded in 2018 (2.9 per 1,000 live births), a year in which, unlike in 2019, the value recorded was up from the previous two years. Infant mortality values were higher for boys than for girls (2.7 per 1,000 live births for boys, 2.3 for girls).
The greatest contribution to the decrease came from the South and Islands, where the rate went from 3.7 to 2.9 per 1,000 live births, and from the Centre, where the rate went from 2.6 to 2.0 per 1,000 live births. In the North, however, the rate remained constant compared to 2017 and 2018 (2.4 per 1,000).
In adulthood (people aged 20-64), mortality from malignant tumours, which is considered premature, is particularly relevant. In 2019, the mortality rate for these diseases was 8.1 per 10,000 residents, a value that has gradually decreased in recent years. In 2019, the reduction affected both women and men: the mortality rate from malignant tumours for women stood at 7.5 per 10,000 residents (it was 7.7 in 2018), while that of men stood at 8.8 per 10,000 residents (it was 9.3 in 2018). At the territorial level, higher values of mortality from malignant tumours were confirmed also in 2019 in the South and Islands (8.7 per 10,000 inhabitants against 7.5 in the North-east and 8.0 in the North-west and Centre).
The highest value of the indicator, for both men and women, was recorded in Campania (10.5 and 9 per 10,000 inhabitants, respectively), but while a reduction was observed for men in this region compared to the previous year (it was 11.1 in 2018), on the contrary, a slight increase was observed for women (it was 8.9 in 2018), which cancelled out the gain that had been observed for this cause in 2018.
In 2020, the death rate from road accidents among young people stood at 0.5 per 10,000 residents aged 15-34. Compared to the period 2013-2019, in which the indicator had remained completely stable (0.7 deaths per 10,000 residents aged 15-34), a reduction was

observed in 2020, partly attributable to lower mobility in the area at certain times of the year, due to travel restrictions to contain the spread of the COVID-19 pandemic.
A strong gender difference is also confirmed for 2020, with a value of 0.8 per 10,000 residents among males and 0.2 among females. The reduction in the indicator in 2020 was only observed for men (the rate was 1.1 per 10 thousand in 2019), while no change was recorded among women.
From a territorial point of view, the mortality rate for road accidents in 2020 shows almost completely overlapping values in the various territorial macro-areas, only in the North-west is a slightly lower value observed (0.4 per 10,000 residents aged 15-34).
In a country like Italy, characterised by a very high life expectancy and therefore a considerable proportion of elderly people, diseases such as dementia and diseases of the nervous system, for which the mortality rate in 2019 was 34 per 10,000 inhabitants, are widespread. Women have a mortality rate of 32.7, men 35.1.
After an almost constant increase from 2015 until 2017 and a subsequent slight decrease in 2018, an increase is observed in 2019 compared to the previous year (when the mortality rate was 33.3 per 10,000 inhabitants). The increase affected both men and women equally.
The highest mortality rates due to dementia and diseases of the nervous system are found mainly in the North (36.7 per 10,000 inhabitants in the North-west and 36.0 in the North-east) and on the Islands (34.2 per 10,000 inhabitants), and less so in the Centre (32.4 per 10,000 inhabitants) and in the South (29.5 per 10,000 inhabitants).

Sedentary lifestyles in the total population decreased, but increased among adolescents

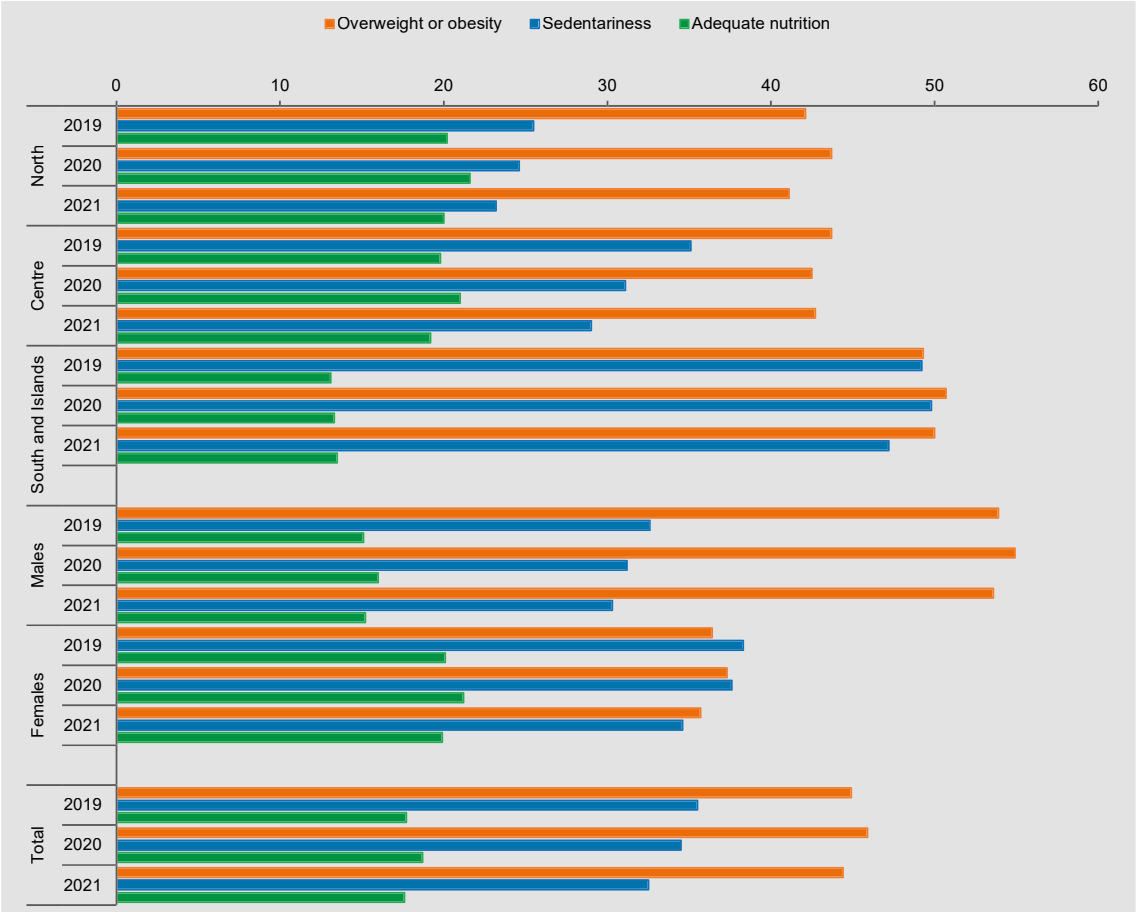
The two-year period 2020-2021 was strongly characterised by the spread of the COVID-19 pandemic. The regulations implemented in order to contain the spread of the virus significantly affected many aspects of everyday life. Especially during the phase 1 lockdown, business closures and imposed travel restrictions led to major changes in the population's lifestyles. Subsequently, in the later stages of the pandemic, people gradually began to return to daily life activities in a similar way as in the pre-COVID period, although the effects of the pandemic continued to affect people's lives and the return to normality at the end of 2021 had not yet been fully achieved.
In 2021, the share of sedentary people was 32.5% (Figure 11). Women were more sedentary than men (34.6% vs. 30.3%), although the gender gap has been narrowing over time (it was 7.8 percentage points in 2010 and fell to 4.3 percentage points in 2021). Sedentariness increases with age: it affects 2 out of 10 people among adolescents and young people up to 24 years of age to almost 7 out of 10 among the population aged 75 and over.
In 2021, the indicator showed a further improvement compared to what was observed in 2020 (34.5%) and 2019 (35.5%), in line with the trend observed since 2014. However, the decrease did not affect 14-19-year-olds for whom there was a significant increase in sedentariness from 18.6% to 20.9%. On the other hand, a substantial decrease in the proportion of sedentary people was observed among the adult population aged 45-59 (-3.2 percentage points) and among the elderly population aged 75 and over (-4.3 percentage points).
What was observed especially in 2021, but which was also partly evident in 2020, was the decrease in continuous sports activity, especially among the very young, aged 14-24, and at the same time the growth of occasional sports activity and the habit of performing physical activities. These forms of activity are often characterised by the fact that they are

carried out in an unstructured manner and outside gyms and sports centres which, during the pandemic period, experienced long periods of closure due to the restrictions imposed to contain the virus.
A strong North-South territorial gradient was also confirmed in 2021, with sedentary rates reaching 23.2% in the northern regions and 47.2% in the southern regions. Compared to 2020, there was a significant decrease in the proportion of sedentary people across the whole territory, but more so in the southern regions (-2.6 percentage points) and in the Centre macro area (-2.1 percentage points).

Slight and steady increase in the proportion of people suffering from obesity over the two-year period

The analysis of excess body weight showed a value of 44.4% among people aged 18 years and over in 2021. This figure was 1.5 percentage points lower than in 2020 (45.9%). Despite the fact that there has been a fluctuation in the overall excess weight indicator over the last 2 years (increased in 2020 by 1 percentage point and decreased in 2021 by a slightly higher amount), what can be observed when analysing the two components of overweight and obesity of which the indicator is composed, was a fluctuation only in the proportion of people in an overweight condition, which in 2020 reached 34.9% (compared with 34.4% in 2019) and in 2021 fell by 1.9 percentage points (to 33.0%). The proportion of people suffering from obesity shows a slight but steady increase, which reached 11.4% in 2021 compared to 10.5% in 2019 and 10.9% in 2020.
Men were found to be more overweight than women (53.6% vs. 35.7%). Excess weight was higher with increasing age (as early as the 45-54 age group, it affected almost 5 out of 10 people) and in the regions of Southern Italy (50.0%). Compared to 2020, there was a decrease in the share of people who were overweight for both men and women, with more significant levels among adults aged 50-64 years (-3 percentage points) and especially in the northern regions (from 43.7% to 41.1%), while in the central and southern regions the situation remained more or less stable.
It is apparent that sedentary behaviour is often associated with excess body weight. These risk factors, alone or in association, generally concern about 60% of the adult population, with a share of about 20% in which both forms of behaviour overlap.
The protective role of educational qualifications was confirmed, with a greater focus on healthier behaviour among those with higher educational qualifications. For example, a higher proportion of overweight people was observed among those with a low educational qualification (54.6%), compared to those with a university degree or higher (33.7%). Similarly, a higher proportion of sedentary people was observed among those with a low educational qualification (48.4%), compared to those with at least a university degree (15.8%).

Figure 11. Standardised proportion of sedentary people aged 14 years and over, standardised proportion of people aged 18 years and over who are overweight/obese, and standardised proportion of people aged 3 years and over who consume at least 4 portions of fruit and/or vegetables daily by geographic area and gender. Years 2019, 2020 and 2021. Percentages



Source: Istat, Survey on Aspects of Daily Life

Fruit and/or vegetable consumption decreased

In terms of healthier eating styles, in 2021 the share of the population aged 3 and over who consumed at least 4 portions of fruit and/or vegetables daily was 17.6%. This share was down by about 1 percentage point compared to the previous year, tending to realign with what was observed in 2019 and continuing to remain at lower levels than in 2015-2018, when this indicator reached almost 20%.

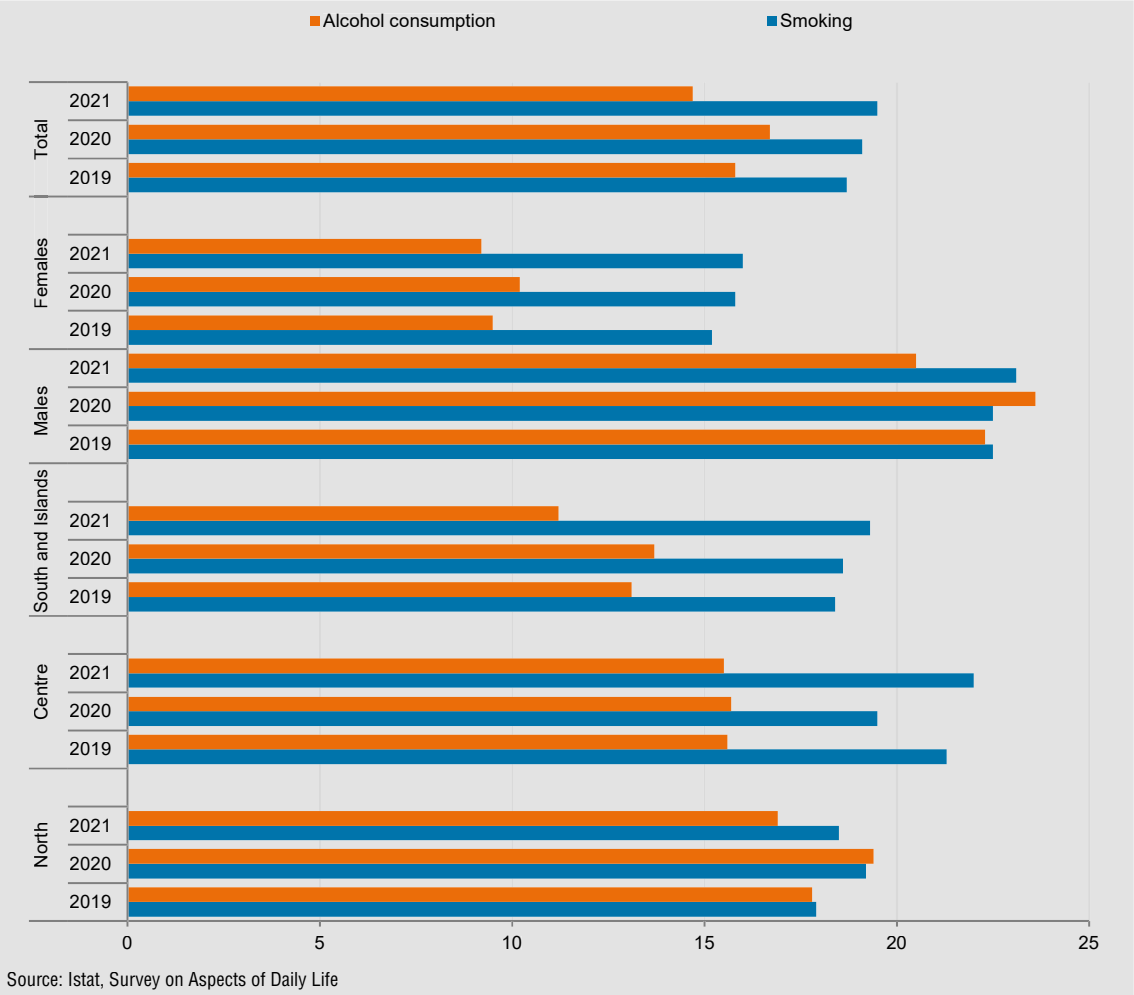
Higher proportions of consumers of at least four portions of fruit and/or vegetables per day were observed in the northern (20.0%) and central (19.2%) regions than in the South and Islands (13.5%). However, while in the South and in the Islands there was no decrease compared to 2020, on the other hand, in the Centre-north the share of daily consumers of 4 or more portions of fruit and/or vegetables decreased by 1.7 percentage points.

More virtuous behaviour was confirmed among women than men (19.9% vs. 15.2%), although the drop recorded over the last year was greater among women (-1.3 percentage points) than men (-0.8 percentage points).

Smoking rates remained stable, increasing only in central Italy

In 2021, the proportion of smokers aged 14 years and over was 19.5%, which is stable compared to 2020 (19.1%) and slightly higher than in 2019 (18.7%) (Figure 12).
In 2021, smokers increased in central Italian regions (from 19.5% to 22%), while they remained more or less stable in Northern Italy and in the South and Islands.
Smoking was more prevalent among men (23.1 % vs. 16 %); however, this gap has narrowed considerably over time (it was 11.2 percentage points in 2010 and reached 7.1 percentage points in 2021).

Figure 12. Standardised proportion of people aged 14 and over who report currently smoking and standardised proportion of people aged 14 and over who have at least one risk behaviour in alcohol consumption by geographic area and gender. Years 2019, 2020 and 2021. Percentages



Source: Istat, Survey on Aspects of Daily Life

The smoking habit was highest among 20-24-year-olds and reached its highest level among 25-44 year-olds (in this age group it involved about one in four people). The proportion of smokers decreased slightly in subsequent age groups, but remained fairly stable up to the 60-64 age group and decreased in subsequent age groups.

Risky alcohol consumption decreased, but the frequency of binge drinking increased

In 2021, risky drinking affected 14.7% of the population aged 14 and over. After a significant increase between 2019 and 2020 (from 15.8% to 16.7%), a significant decrease in the share of risky drinkers of 2 percentage points was observed in 2021 (Figure 12). The decline in the proportion of at-risk consumers affected both habitual binge drinking (back to 2019 levels) and drunkenness, with a more significant reduction in the latter from 8.4 % to 7.1 % in 2021. The decrease in binge drinking habits mainly affected young people among whom this risky drinking behaviour is generally more widespread (in the 18-24 age group, drunkenness decreased by 3.6 percentage points). This trend may also have been affected by the closure of discos and dance venues during the pandemic period, which are often mentioned by young people as the place where their last binge drinking episode occurred (in 2019, more than one in three 18 to 24-year-olds reported it, while in 2021 it affected one in ten).

However, it should be noted that while the number of people reporting at least one binge drinking episode in the last year decreased in 2021, the average number of times a binge drinking episode occurred increased from 6.5 to 7 in 2020.

Riskier drinking habits are confirmed to be more widespread in the northern regions (16.9%), compared to the Centre (15.5 %) and especially in the South and Islands (11.2%). A significant decrease was observed in the regions of the North and the South and Islands (-2.5 percentage points) compared with 2020, while in the regions of Central Italy the situation remained completely stable.

The gender gap remained high also in 2021, with a higher share of men with risky drinking habits (20.5% men vs. 9.2% women); over time, however, the gender gap has narrowed and women's risky behaviour is slowly catching up with men's (in 2010 the gap between men and women was 17.6 percentage points vs. 11.3 in 2021).

Although significantly decreasing compared to 2020, high proportions of at-risk consumers were again observed in 2021 among 14-17-year-olds (23.6%) and 18-24-year-olds (15.9%).

Another age group in which at-risk consumption is high is that of people aged 65 and over, which stands at 18.6%. Unlike for young people, among those aged 65 and over, no decrease in risk consumption was observed in 2021, which was fully in line with the 2020 value (18.8%). It should be noted that the risky consumption behaviour characterising the young and the elderly was clearly different: the former's behaviour was more related to excessive consumption, especially at weekends, while the latter's was of an unmoderated daily nature.

Indicators

1. **Life expectancy at birth:** Life expectancy expresses the average number of years that a child born in a given calendar year can expect to live if exposed during his whole life to the risks of death observed in the same year at different ages.
   Source: Istat - Life tables of Italian population.
2. **Healthy life expectancy at birth:** It expresses the average number of years that a child born in a given calendar year can expect to live in good health on the assumption that the risks of death and perceived health conditions remain constant. It is built using the prevalence of individuals who respond positively ("good" or "very good") to the question on perceived health.
   Source: Istat - Life tables of Italian population and Survey on Aspects of daily life
3. **Mental health index (SF36):** The mental health index is a measure of psychological distress obtained from the synthesis of the scores obtained by each individual of 14 years and over to 5 questions from the SF36 questionnaire (36-Item Short Form Survey). It includes one or more items from each of the four major mental health dimensions (anxiety, depression, loss of behavioural or emotional control, and psychological well-being). The final score is a standardised measure, which varies between 0 and 100, with better psychological well-being corresponding to higher scores.
   Source: Istat - Survey on Aspects of daily life
4. **Avoidable mortality (age 0-74):** Deaths of persons aged 0-74, due to causes identified as treatable (in the light of medical knowledge and technology at the time of death, most deaths from that cause could be avoided through optimal quality health care) or preventable (in the light of understanding of the determinants of health at the time of death, most deaths from that cause could be avoided by public health interventions in the broadest sense). The definition of the lists of treatable and preventable causes of mortality is based on a joint OECD/Eurostat work, revised in November 2019. Standardized rates with European 2013 population aged 0-74, per 10,000 residents.
   Source: Istat - Vital register on deaths and causes of death
5. **Infant mortality rate:** Deaths during the first year of life per 10,000 born alive.
   Source: Istat - For deaths: Vital register on deaths and causes of death. For live births: Migration and calculation of yearly resident population
6. **Road accidents mortality rate (15-34 years old):** Mortality rate in road accidents by five year age groups for people aged 15-34 years, standardised by the European 2013 population of the same age groups.
   Source: Istat - For deaths: Survey on road accidents resulting in death or injury. For population: Survey on the municipal resident population by sex, year of birth and marital status
7. **Age-standardised cancer mortality rate (20-64 years old):** Mortality rate for cancer (initial cause) by five year age groups for people aged 20-64 years, standardised by the European 2013 population in the same age groups.
   Source: Istat - For deaths: Istat, Survey on deaths and causes of death. For population: Survey on the municipal resident population
8. **Age-standardised mortality rate for dementia and nervous system diseases (65 years and over):** Mortality rate for nervous system diseases and psychical and behavioral disorders (initial cause) by five year age groups for people aged 65 years and over, standardised by the European 2013 population in the same age groups.
   Source: Istat - For deaths: Istat, Vital register on deaths and causes of death. For population: Survey on the municipal resident population
9. **Multimorbidity and severe limitations (75 years and over):** Percentage of people aged 75 and over who declare to be affected by 3 or more chronic conditions and/or to be severely limited, for at least the past 6 months, because of a health problem in activities people usually do.
   Source: Istat - Survey on Aspects of daily life
10. **Life expectancy without activity limitations at 65 years of age:** It expresses the average number of years that a person aged 65 can expect to live without suffering limitations in activities due to health problems. It is based on the prevalence of individuals who answer to be limited, for at least the past 6 months, because of a health problem in activities people usually do.
    Source: Istat - Life tables of Italian population and Survey on Aspects of daily life
11. **Overweight or obesity (standardised rates):** The indicator refers to the Body Mass Index (BMI), which classifies people as overweight (25 <= BMI <30) or obese (BMI> 30) as classified by the World Health Organization (WHO). The indicator is standardised using the 2013 European standard population.
    Source: Istat - Survey on Aspects of daily life
12. **Smoking (standardised rates):** Proportion of people aged 14 and over who report current smoking. The indicator is standardised using the 2013 European standard population.
    Source: Istat - Survey on Aspects of daily life
13. **Alcohol consumption (standardised rates):** Proportion of people aged 14 and over who are at-risk consumers of alcohol. Taking into account the definitions adopted by the WHO and the recommendations from INRAN, in agreement with the National Institute of Health, are identified as "at-risk consumers" all those individuals who have at least one risk behaviour, exceeding the daily consumption of alcohol (according to specific thresholds for sex and age) or concentrating on a single occasion of consumption the intake of 6 or more units of any alcoholic drink (binge drinking). The indicator is standardised using the 2013 European standard population.
    Source: Istat - Survey on Aspects of daily life
14. **Sedentariness (standardised rates):** Proportion of people aged 14 and over referring not to play sports neither continuously nor intermittently during their spare time, and people aged 14 and over referring not to perform any physical activity, such as walking at least 2 km, cycling, swimming, etc. The indicator is standardised using the 2013 European standard population.
    Source: Istat - Survey on Aspects of daily life
15. **Adequate nutrition (standardised rates):** Percentage of people aged 3 years and over who say they take every day at least 4 portions of fruit and vegetables. The indicator is standardised using the 2013 European standard population.
    Source: Istat - Survey on Aspects of daily life

Indicators by region and geographic area

REGIONS GEOGRAPHIC AREAS	Life expectancy at birth (a) 2021 (*)	Healthy life expectancy at birth (a) 2021 (*)	Mental health index (SF36) (b) 2021	Avoidable mortality (age 0-74) (c) 2019	Infant mortality rate (e) 2019	Road accidents mortality rate (15-34 years old) (f) 2020	Age-standardised cancer mortality rate (20-64 years old) (g) 2019
Piemonte	82.4	60.8	66.8	17.0	2.4	0.5	8.5
Valle d'Aosta/Vallée d'Aoste	82.2	63.2	66.6	16.5	2.4	-	7.9
Liguria	82.6	62.7	69.4	16.3	2.6	0.5	8.0
Lombardia	83.1	61.1	68.2	15.2	2.2	0.4	7.8
Trentino-Alto Adige/Südtirol	83.5	66.3	70.8	13.9	1.8	0.6	7.1
Bolzano/Bozen	*83.2*	*67.2*	*72.2*	*14.6*	*1.5*	*0.9*	*7.1*
Trento	*83.7*	*65.5*	*69.4*	*13.3*	*2.1*	*0.4*	*7.0*
Veneto	83.2	60.6	69.5	14.2	2.6	0.5	7.3
Friuli-Venezia Giulia	82.1	60.9	68.7	15.9	2.0	0.3	7.9
Emilia-Romagna	82.9	61.2	68.8	14.9	2.8	0.6	7.6
Toscana	83.1	62.6	68.5	15.2	1.5	0.5	7.9
Umbria	83.1	61.1	65.4	14.3	1.6	0.7	8.1
Marche	83.0	60.1	65.3	14.6	2.2	0.4	7.3
Lazio	82.6	61.4	68.3	17.4	2.4	0.4	8.3
Abruzzo	82.3	60.5	68.0	16.2	3.1	0.5	7.8
Molise	81.1	58.5	68.7	17.2	1.6	1.0	8.2
Campania	80.6	59.5	68.9	20.2	2.7	0.4	9.7
Puglia	81.8	59.5	68.0	16.2	2.2	0.6	8.2
Basilicata	82.0	57.0	67.5	16.5	3.5	0.6	7.4
Calabria	81.3	54.4	68.9	18.4	4.4	0.4	8.2
Sicilia	80.9	58.8	67.8	18.6	3.3	0.5	8.4
Sardegna	82.5	57.9	71.1	17.8	1.8	0.9	8.9
North	82.9	61.2	68.5	15.4	2.4	0.5	7.8
North-west	82.8	61.2	67.9	15.9	2.3	0.4	8.0
North-east	83.0	61.4	69.3	14.7	2.5	0.5	7.5
Centre	82.8	61.6	67.8	16.1	2.0	0.5	8.0
South and Islands	81.3	58.7	68.6	18.2	2.9	0.5	8.7
South	81.3	58.8	68.6	18.1	2.9	0.5	8.7
Islands	81.3	58.6	68.6	18.4	3.1	0.5	8.6
Italy	**82.4**	**60.5**	**68.4**	**16.5**	**2.5**	**0.5**	**8.1**

(a) Average number of years;
(b) Standardised mean values;
(c) Standardised rates per 10,000 residents;
(d) Per 100 persons aged 75 years and over;
(e) Standardised rates per 1,000 resident live births;
(f) Standardised rates per 10,000 residents aged 15-34;
(g) Standardised rates per 10,000 residents aged 20-64;

Age-standardised mortality rate for dementia and nervous system diseases (65 years and over) (h)	Multimorbidity and severe limitations (75 years and over) (d)	Life expectancy without activity limitations at 65 years of age (a)	Overweight or obesity (i)	Smoking (l)	Alcohol consumption (l)	Sedentariness (l)	Adequate nutrition (m)
2019	2021	2021 (*)	2021	2021	2021	2021	2021
36.2	43.2	10.1	39.3	21.3	17.8	29.0	23.7
50.8	42.3	9.9	41.0	19.9	20.6	18.2	19.7
34.5	42.7	10.9	38.4	18.3	15.1	22.7	18.0
37.3	46.7	10.9	40.2	18.8	16.0	21.9	18.8
36.0	40.3	10.5	40.1	17.8	19.9	13.6	19.9
38.4	*46.0*	*8.9*	*40.6*	*18.0*	*19.5*	*15.4*	*14.1*
34.0	*35.6*	*11.9*	*39.6*	*17.6*	*20.3*	*11.8*	*25.5*
39.2	43.0	10.4	44.6	15.8	17.1	22.2	18.0
29.9	43.0	10.1	42.8	18.2	20.0	22.1	21.3
34.6	42.6	9.8	41.6	18.5	16.8	24.4	21.5
32.9	43.7	10.1	41.9	23.1	16.9	25.0	19.3
32.8	53.8	9.2	43.8	21.0	17.8	30.0	21.2
36.7	52.4	10.8	42.9	21.6	17.6	28.2	20.2
30.3	42.6	9.5	43.1	21.6	13.9	31.5	18.7
35.3	50.5	9.5	46.4	19.5	15.0	31.1	14.8
25.7	48.7	10.2	51.0	19.1	20.1	44.1	15.2
27.8	55.0	8.4	53.9	21.0	10.3	52.6	13.4
31.6	49.8	8.3	49.5	17.9	10.5	45.8	11.4
29.6	54.3	8.5	54.6	19.0	13.5	48.5	9.5
25.3	63.5	8.6	50.1	17.0	12.3	49.0	14.3
31.7	59.8	8.0	49.0	19.1	8.9	51.0	13.2
40.8	51.9	9.3	41.3	20.5	16.5	30.0	18.0
36.4	44.1	10.4	41.1	18.5	16.9	23.2	20.0
36.7	45.1	10.7	39.7	19.4	16.4	23.9	20.0
36.0	42.6	10.1	42.9	17.3	17.6	22.4	19.9
32.4	45.2	9.8	42.7	22.0	15.5	29.0	19.2
31.1	55.2	8.5	50.0	19.3	11.2	47.2	13.5
29.5	53.9	8.6	51.4	19.2	11.4	47.9	13.0
34.2	57.8	8.3	47.1	19.5	10.8	45.7	14.4
34.0	**47.8**	**9.7**	**44.4**	**19.5**	**14.7**	**32.5**	**17.6**

(h) Standardised rates per 10,000 residents aged 65 and over;
(i) Standardised rates per 100 persons aged 18 and over;
(l) Standardised rates per 100 persons aged 14 and over;
(m) Standardised rates per 100 persons aged 3 and over.
(*) Provisional data.