A RANDOM POPULATION STUDY OF THE
DIETARY HABITS OF ELDERLY PEOPLE

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SYNOPSIS

The usual food consumption patterns of a representative sample of 2195 people aged 65 years and over in Adelaide were examined, and the relation of social, psychological and physiological factors to dietary intake in this population explored. The subjects were randomly selected from the State Electoral Roll and there was a seventy seven per cent response.

The principal findings were:

(1) Most elderly people, including those living alone, ate a varied diet; they ate on average seven cooked meals per week and rarely or never missed meals.

(2) Most mean estimated nutrient intakes were above the recommended levels. The nutrients for which respondents appeared most likely to be at risk (by comparison with recommended intakes) were: folate, calcium, magnesium, copper, zinc, potassium, and vitamin B6.

(3) In terms of current dietary guidelines, the diet of elderly Australians was excessive in fat (particularly saturated fat) and refined carbohydrates, and was inadequate in complex carbohydrates and dietary fibre.

(4) The dietary habits of elderly women were more compatible with dietary recommendations (eg. concerning intake of wholegrains, fruit, fats and fatty foods, salt, high-cholesterol foods) than were those of elderly men.
(5) Specific subgroups in the elderly population were identified as being at higher risk of poor dietary intake, namely:

(i) *Elderly men living alone* who were more likely than those living with their wife, to have poor dietary habits.

(ii) *Low socioeconomic status groups.*

Socioeconomic status differences in dietary patterns were prominent, with several favourable dietary behaviours being less common in the lower social classes. In particular, the lower social status groups were characterised by a lower consumption of high fibre and vitamin C-rich foods (fruits, vegetables, wholegrain bread) and more frequent intakes of several high fat foods and salt. Poorer quality dietary intakes in elderly people whose only source of income was a government pension, was a cause for concern.

(6) Living alone had the greatest negative impact on the dietary habits and estimated nutrient intakes of men. Women living alone had, on the other hand, estimated nutrient intakes equal to or greater than those of women living with a spouse.

(7) Within the age group examined, advancing age was generally not associated with a diminished food or estimated nutrient intake; however a number of new food products and cooking methods were more popular with the 65-69 year age group than the older age groups.

(8) Use of dietary supplements in the elderly was widespread, particularly among women. Regular supplement users had greater estimated nutrient intakes from diet alone and reported practicing more dietary behaviours compatible with the dietary guidelines than non-supplementers.
Overweight or obesity was very common among elderly men and women. However the vast majority of overweight or obese people were not following a weight reduction diet. In addition, apart from a lower intake of sugar and sugary foods, they were no more likely than the underweight or those of normal weight to be practicing dietary habits that would help to reduce energy intake. The kinds of foods eaten were not important predictors of body mass index.

The prevalence of special diets in elderly people with specific diet-related medical conditions was low. Furthermore, dietary modifications potentially of benefit in specific diet-related medical conditions were generally no more common in people with the conditions than in those without them. Diabetics, for example, had lower intakes of refined carbohydrate, but they were just as likely as nondiabetics to eat high fat foods, and they ate eggs and cheese more frequently than nondiabetics. They were no more likely to consume the recommended complex carbohydrate and fibre-rich foods. People with a heart condition were no more likely than others to be making dietary modifications which help to reduce fat or saturated fat intake.

Lifestyle, as measured in terms of participation in a variety of different social and physical activities, was the best predictor of dietary intake; a varied lifestyle being associated with a varied diet. The lifestyle variable together with the other variables related to dietary habits (e.g. living arrangement, occupational status) accounted for 20 per cent of the variance in the dietary variety scores.

Other factors found to be associated with poor dietary intake were: poor health, diminished enjoyment in eating, poor appetite, reduced feelings of vigour/activity, feelings of fatigue/inertia, shopping difficulties and the experience of a number of specific life difficulties.
(13) Dietary intake was found to be largely independent of: feelings of depression/dejection, recent bereavement, the presence of food avoidances and eating related problems, the self-perception of chewing difficulties or of poorly fitting dentures.

(14) A random sample of the original study population was followed up approximately 18 months after the initial study. A high degree of dietary change had occurred since the original study, particularly among the 65-69 year age group, with the most commonly reported changes being largely in accord with the dietary guidelines.