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Food Choice and the Elderly: European Qualitative Research Summary

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Campden & Chorleywood Food
Research Association Group

Campden & Chorleywood Food
Research Association Group

Chipping Campden
Gloucestershire
GL55 6LD, UK

Tel: +44 (0)1386 842000
Fax: +44 (0)1386 842100
www.campden.co.uk

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HC Newsholme and JA McEwan

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This report was completed based on work undertaken by:

Robert G Neilson, Biotechnological Institute - Denmark

Gunnar Hall, SIK - Sweden

Anne Valendru and Jean A McEwan, CCFRA - United Kingdom

David Martinez and María José Sanchez, AINIA - Spain

Emanuelle Vrignon, ADRIANT- France

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EXECUTVE SUMMARY

The elderly population in Europe has gradually increased and is set to rise by 15 million by 2010 (PROMAR1999). Maintaining good health as age increases is important to the quality of life of the individual and the economic health of the country. Food and nutrition play an important role in the maintenance of good health and there has been little investigation up to now into the changing needs of this important sector of the population. A wider understanding of the physical, social, physiological and emotional requirements, and barriers this age group encounter to a healthy diet will enable countries to address these problems and satisfy requirements.

To investigate attitudes and behaviour towards food among elderly people, qualitative studies in the five European countries of Denmark, Sweden, UK, France and Spain were undertaken. Focus groups and in-depth interview techniques were used in each country using discussion guides following similar guidelines. The objective of this report is to bring together the results from these 5 studies, highlighting similarities and differences between and within countries.

The European elderly ate a variety of foods, which were generally consumed at three meal times: breakfast, lunch and dinner. The time the main meal of the day was taken varied within and between countries. Snacking between meals was not reported to be a frequent occurrence for most of the elderly, neither was the drinking of alcohol with the exception of French elderly males.

Many factors shown to influence food choice were seen to be common throughout all the European elderly. One of the strongest influences on food choice for many of the elderly was habit and tradition. For the French and the Spanish, tradition was a strong influence in food choice and meal occasions. For the UK, Sweden and Denmark, traditional methods of cooking and preparation were prevalent, but tended to be continued out of habit rather than a strong sense of pride in their nations' cuisine.

For many, the quality of food was reported to influence food choice over and above price. Quality was often defined as fresh ingredients and cooking meals from raw

ingredients without the use of convenience or processed products. The use of ready meals and convenience foods was minimal among the elderly mainly for this reason.

Although price was not reported to affect choice for the majority, many reported to look for bargains and shop at supermarkets where prices were lower. For some, particularly in the UK and Spain, bargains and special offers seemed to be the main determinant of food choice.

Mobility, in respect of having personal transport, was extremely important to many of the elderly, particularly in the UK, Denmark and Sweden. For those in France and Spain, alternative modes of transport, delivery services or friends and family were utilised where the elderly did not have their own transport.

Other factors including nutritional aspects, location, ease of preparation and to a lesser extent packaging, influenced the food choice of some of the European elderly.

The social context of eating was extremely important to the European elderly. The effort made in preparation and cooking just for oneself was not seen as worthwhile as it was for other people. Eating alone was not as enjoyable as eating in company. Those who had lost a partner were often affected the most. The social aspects of eating depended on the culture of the country. For the French and the Spanish the whole culture revolved more around food and meal occasions and so family gatherings were much more frequent for many of the elderly than in the other countries. In the UK, shopping was often more of a social occasion than meal times.

Dietary changes were mainly associated with life stage changes related to ageing including: children leaving home, retirement, onset of illness and loss of partner. A reluctance to admit dietary change by many could possibly be linked to a reluctance to admit ageing.

For the majority, influences on food choice, barriers to eating a healthy diet and reasons for dietary change were rarely attributed to physiological or physical problems associated with ageing. It is suggested that there may have been reluctance

for some to admit to certain physical or physiological problems which may have affected food choice due to the reticence of some in admitting to old age.

Attitudes to food were divided within countries and were found often to be consistent between countries. Several similar attitudes were identified and in the UK, Spain and France; these were named according to featuring characteristics. These included traditionalists (those influenced mainly by tradition), hedonists (those who lived to eat), survivors or apathetic (those who ate to live), people of duty (those who felt obliged to cook wholesome meals without use of convenience foods), those inhibited or repressed (those with nutritional concerns over and above enjoyment of food) and home-economists (those to whom finding the best price or bargain influenced choice). It was apparent that within each country, a proportion of the elderly could fall into these categories.

The extent to which the different attitudes existed within the elderly populations depended on the country, the life stage changes that had occurred and to some extent the age of the respondents. Attitudes to food had a strong influence on barriers to eating a healthy diet and dietary change.

Many of the elderly agreed that physical, mental and social wellbeing was important to a healthy lifestyle. The incorporation of a healthy diet within the context of a healthy lifestyle was seen as important to many. The interpretation of healthy diet, however, was variable and often confused. Thus, perceptions of a healthy diet were not consistent.

CONTENTS

1. INTRODUCTION

1.1 Background

There has been a gradual ageing of the population on a worldwide scale. An increase in healthcare, medical and technological developments leading to reduced infant mortality and increased longevity has contributed to this. The percentage of people aged 60 years and above is set to increase from 10% (in 1995) to 31% in 2150 (United Nations 1999). In the 15 EU member states, the percentage of the population aged over 55 is set to rise from 26% in 1998 to 31% by 2010 and to grow by 15 million (PROMAR 1999).

Good nutrition plays a vital role in health and longevity, and the quality of the diet is important at any age. However, for more vulnerable groups, such as the elderly, it is important that nutritional requirements are met to reduce the risk of disease and death.

Many diseases associated with ageing not only have an increased risk with a poor diet, but also healthy eating can reduce risk. Diseases such as Type 2 diabetes (non-insulin dependent diabetes), cardiovascular disease (including heart disease and strokes) and osteoporosis are significantly affected by diet.

There is a gradual decline in lean body mass with age, often coupled with a decrease in physical activity, so energy requirements are lower than for younger people. Increase in energy intake above these requirements will lead to overweight and obesity. Obesity is a risk factor for many problems including high blood pressure and diabetes, which in turn increase the risk of cardiovascular disease. On the other hand failing to meet energy requirements may mean both macro- and micro-nutrient intake is compromised, which can create more problems for the elderly.

The benefits of good nutrition for the health of an ageing population are important from both the individual and global economic aspect. Remaining healthy as age progresses has the obvious benefits of increased quality of life and life expectancy for the individual. From an economic point of view, increasing numbers of elderly people will

lead to increasing the strain on healthcare systems. Elderly people are more susceptible to malnourishment, they tolerate it poorly and the consequences can be severe. Thus, improving nutritional status amongst this growing sector of the population will mean better health, and so decreased economic pressure on healthcare systems.

The food industry in Europe already provides, to some extent, for those sectors of the population with particular needs. For example, special foods have been manufactured for the feeding of infants and babies and in the UK many supermarkets have parking spaces for those with families to assist with the convenience of shopping. There has, however, been little provision made for the elderly sector of the population. In advertising, 95% of all European advertising targets the youth market (Curtis, 1999) suggesting that the lack of provision in the food sector is mirrored in other industries by the disproportionate amount of marketing aimed at the older sector.

In order to address the needs of the ageing population it is first necessary to understand what these needs are. Although the implications of diet and health in the elderly are clearly seen, there has been little investigation into the attitudes of the elderly towards food related issues and how these affect food choice behaviour.

There are many factors including psychological, physiological, social and financial that may influence food choice in the elderly population. Understanding these influences will aid the industry to respond to and provide for the real needs of the ageing consumer.

In order to achieve this end, qualitative studies in five European countries (Denmark, France, Spain, Sweden and UK) have been undertaken. This report draws together these studies in order to help identify key aspects relating to attitudes and behaviour of the European elderly population.

1.2 Objectives

❶ To bring together the results from the qualitative research into attitudes of the elderly with respect to food related issues carried out in the five European countries of Sweden, Denmark, United Kingdom, France and Spain.

❷ To highlight similarities and differences in attitudes and behaviour within and between countries.

1.3 Scope

This report brings together the qualitative research carried out in the five European countries of Sweden, Denmark, United Kingdom, France and Spain. Results from this report will be used to help identify key issues to be addressed in the pan-EU quantitative survey and provide valuable information with respect to the formation of future EU policies to encourage healthier ageing within the European population. The main barriers to a healthy lifestyle, focussing on diet and health, and implications for future elderly generations will also be considered within the scope of this report.

2 METHODS

2.1 Reports from Five European Countries

This report aims to pull together the qualitative studies of five European countries. To provide an understanding of how these reports evolved, the methods by which these studies were carried out is summarised below.

2.1.1 Recruitment Criteria

A series of group discussions and in-depth interviews were conducted in five European countries (Sweden, Denmark, United Kingdom, France, and Spain) in accordance with agreed research guidelines (EU Technical Annex 2000 - HealthSense). Recruitment criteria were the same for each participating country, ensuring a similar distribution of respondents according to age, gender, level of education, number of household members and social status. Subjects who had lived outside their country in the previous 10 years were excluded, as were those with dietary restrictions and diabetes. In addition, only those responsible for the shopping and preparation of at least three main meals per week were included. An example of a recruitment questionnaire (used in UK study) can be seen in Appendix 1.

2.1.2 Fieldwork

For each country the fieldwork consisted of group discussions and in-depth interviews, the locations of which can be seen in the individual reports. Table 1 shows the number of group discussions and in-depth interviews in each country.

Table 1: Summary of groups and in-depth interviews.

	Sweden	Denmark	UK	France	Spain	Total
Focus Groups	6	6	8	6	8	34
Interviews	20	22	54	20	25	141
Couples	-	-	15	2	-	17

Discussion and interview guides for each country followed the same format and covered a wide range of topics including consumption, preparation, purchase and storage and also questions specifically pertaining to healthy eating. In most instances, focus groups took place in hired venues for around 2 hours. In-depth interviews took place mainly in people's homes in order to include older respondents or those who were mainly house bound.

2.1.3 Sample Details

Sample details from individual countries can be seen in the respective country's report The numbers and division of gender for those taking part in the study are summarised in Table 2.

Table 2: Distribution of males and females in each country.

	Sweden	Denmark	U K	France	Spain	Total
Male	34 (46%)	38 (49%)	44 (38%)	31 (44%)	42 (43%)	191 (44%)
Female	40 (54%)	40 (51%)	56 (49%)	40 (56%0	53 (55%)	227 (52%)
Couples	-	-	15 (13%)	-	2 (2%)	17 (4%)
Total	74	78	115	71	97	435

Respondents were recruited in 4 different age groups (55-64, 65-76, 76-84 and 85+). National statistics were taken into consideration when recruiting respondents within these age groups; however, for various reasons (including difficulty in recruiting very elderly and men), numbers did not always reflect the exact population. The distribution of respondents in the different age groups is summarised in Table 3.

Table 3: Distribution of ages in each country.

	Sweden	**Denmark**	**U.K.**	**France**	**Spain**	**Total**
55-64	22	22	31	23	25	**123**
65-76	24	28	58	22	35	**167**
77-84	28	21	19	26	37	**145**
85+		7	7			
Total	**74**	**78**	**115**	**71**	**97**	**435**

Both city and rural locations were targeted in each country. The number of rural respondents for each country varied depending to a great extent on the comparative population of elderly living in rural locations. Further details of respondents from each country can be found in the individual reports.

2.1.4 Discussion Guide

The main key areas of the discussion guide were identified and then adapted appropriately for use in each individual country. The key issues to be discussed were as follows

- Eating habits
- Healthy eating
- Food preparation
- Food storage
- Food shopping

An example of a discussion guide (used in UK study) can be seen in Appendix 2.

2.2 Summary Report

In order to pull together the qualitative reports from the five European countries, the six key areas detailed in the original proposal for the quantitative survey were referred to as follows:

- Perceived important influences to food choice
- Main perceived barriers to eating a healthy diet
- Dietary change
- Exploration of social context
- Mentality towards food
- Healthy lifestyle

The eating habits of the elderly in each of the countries were firstly summarised in order to provide a framework from which to proceed.

The behaviour and attitudes of the elderly in each of the countries were then examined in the context of the above headings.

Although following similar guidelines, individual reports from each country were written in different styles. The information reported, therefore, was not always concurrent. In some reports, more detail was provided than in others relating to specific areas and thus examining cross-cultural similarities and differences was not always possible for all countries, for certain aspects of food related behaviours. Where attitudes and behaviours have not been reported it was not assumed that they did not exist. The final chapter includes the authors comments regarding underlying trends, which although not always specifically reported, by their omission, may have existed between and within countries.

3. EATING HABITS AND PLANNING OF MEALS

Before examining the factors that influence food choice and by way of introduction to eating behaviours of the elderly, the typical meals and eating habits in each of the countries have been summarised.

3.1 Typical Food and Eating Habits

Denmark

In Denmark the majority of the elderly respondents were reported to eat three meals a day. The main meal was always a hot meal either taken around 5-7pm or around midday, the latter being more a tradition in the country areas. Some of the respondents ate snacks in between meals and these were reported to be, typically, items such as apple, carrots, biscuits, or a slice of bread with cheese. As age increased, smaller snacks were reported to be taken throughout the day.

Breakfast consisted of a variety of foods including cereals, milk and bread, cheese, fresh fruit or yoghurt often with coffee, tea or juice. Lunch consisted, more often than not, of Danish open sandwiches consisting of rye bread with various toppings including sliced meat, egg or tomato. Some, in the youngest age group, often skipped lunch. Dinner generally consisted of a meat dish, vegetables and potatoes, rice or pasta usually eaten with some rye bread. Chicken, turkey, ham and pork were reported to be eaten frequently and in general, meat was eaten three times a week. Fish was eaten regularly and for some it was eaten every day. Vegetables were usually boiled although salad and raw vegetables were reported to be eaten frequently (more so in the youngest age groups). Sweet snacks and desserts were reported to be eaten infrequently by all groups.

Drinking water was seen as very important for many of the Danish elderly respondents. Many believed they should be drinking 2 litres a day and tried to adhere to this. Alcohol

was not reported to be popular among the elderly in Denmark. It was mentioned only once in the context of having the occasional glass of red wine with the meal.

Sweden

All Swedish respondents reported to eat breakfast, lunch and dinner and light snack/supper on weekends and weekdays. The time of main meal varied, with some having their main meal for dinner (between 4-7pm) and some at lunch (between 12-4pm). This often depended on whether respondents were still working. Those still in work tended towards a lighter breakfast and heavier lunch. Others still working ate a light breakfast at home and their main breakfast at work (e.g. manual workers, pre-school teachers). Breakfast times varied from around 8-10am and light evening snack was reportedly taken between 6-9pm.

Breakfast included tea or coffee and consisted generally of one or more of the following: fruit juice, yoghurt or other soured milk product, cereal, eggs, sandwiches, toast and marmalade and fruit. In winter, people tended towards hot cereals rather than the cereal and cold milk they ate in the summer. Weekend breakfasts were reported to be more substantial and often richer.

The food eaten at the main meal of the day included meat (mainly beef and pork, sometimes sausages or bacon), poultry or fish plus vegetables and potatoes, rice or pasta. Some were hunters or had hunters in the family and so often included game meat. Fish was eaten by most of the Swedish respondents once or twice a week. Potatoes were preferred to rice, then pasta as an accompaniment to meat or fish for the main meal of the day. Vegetables were eaten either as salad, steamed or raw. Desserts were rarely eaten on the weekdays, but often at weekends, particularly when there were visitors for dinner. These could be fruit, ice cream, berries, pies and puddings. Weekends tended to be slightly more special, taking longer to prepare the food and often using a more expensive cut of meat or type of seafood.

The lighter meal of the day often included eggs, e.g. as an omelette, or bacon and eggs. Other foods eaten at this meal included herring, black pudding, pies, soup, leftovers,

yoghurts and cereals, sandwiches and fruit, with coffee or tea to drink. Snacks between meals were not recorded in detail but were reported to include a cup of tea/coffee.

Drinks included water, beer and wine. Wine was more frequently drunk at the weekends although it was not reported to be consumed regularly by the majority. Some of the women reported to drink a large glass of water to start their day.

United Kingdom

The elderly in the UK reported to typically eat three meals per day, consisting of breakfast, lunch and dinner. Snacking in between meals was not reported to occur frequently in this group, although many had a snack before going to bed. Dinner was reported to be eaten around 6pm. Other meal times were not reported.

Breakfast was generally based around cereals and/or toast. Poached eggs on toast were also popular and fruit was eaten, by some, for breakfast.

Lunch consisted mainly of a sandwich with cold meat, cheese or canned fish (e.g. tuna). Salad vegetables, for example, tomato, cucumber, lettuce or coleslaw, was often included in the sandwich. This was often supplemented by or replaced with hot soup in the winter.

The evening meal was the hot meal of the day with the exception of Sundays when some prepared a traditional roast dinner to eat around midday. The hot meal of the day typically consisted of meat (e.g. pork, beef, chicken, chops, steak, gammon) with potatoes and vegetables. Salad was mentioned as an occasional variation from vegetables and fish was also mentioned as an alternative to meat. Frequency of consumption was not reported.

Consumption of beverages was not reported in the UK study.

France

The elderly in France generally ate three meals a day: breakfast, lunch and dinner. The meal at lunchtime was the main meal of the day and the meal in the evening was generally reported to be a lighter meal. Some of the younger elderly reported to have their main meal in the evening.

Breakfast consisted of coffee and toast often accompanied by orange juice. Yoghurt was also popular at breakfast.

The lunchtime meal comprised 4 courses. The appetiser was most often a salad of raw vegetables in season or assorted meats. The main course comprised meat or fish and vegetables. These were often put together, e.g. *pot au feu* (boiled beef and vegetables), particularly in the winter months. This was often followed by salad or cheese and a dessert.

The evening meal was often soup or omelette followed by cheese or yoghurt. Cheese was eaten by most respondents on a daily basis and often replaced dessert at lunch. Snacking between meals was not reported often by the French respondents.

Wine was reported to be drunk often with the main meal, particularly amongst the men. The women tended to prefer mineral water. Water either from the tap or mineral water was reported to be drunk with the main meal by the majority of respondents.

Spain

In Spain a typical days eating would consist of breakfast around 8-10am, lunch around 2pm and dinner around 9pm. The main meal would be invariably at lunchtime with a lighter or smaller meal at supper. Generally speaking, the elderly in Spain reported to eat a variety of food with a high consumption of vegetables, salads and fruit. Olive oil was reported to be consumed in large quantities. Dairy products including yoghurt and cheese were also popular.

Breakfast usually consisted of milk or coffee with biscuits, sweet rolls and cereals. A mid-morning snack consisting of a piece of fruit or yoghurt was often taken by many of the respondents.

The main meal typically consisted of a starter, a main course and a dessert. The starter may be a broth or soup; the main dish could be paella or stew accompanied by a salad followed by a dessert and often coffee. For some, a cup of coffee and biscuits would be taken around 5.30pm as an afternoon snack. The evening meal would generally be a light meal or a meal similar to lunch but taken in a smaller quantity. Fish was reported to be preferred by most over meat and, for many, food was boiled or roasted rather than fried.

Consumption of beverages was not reported to any extent in the Spanish study, although it was mentioned that for a special meal an aperitif may be taken, and coffee was often drunk after a meal; the consumption of other beverages was not recorded.

3.2 Planning Meals

In France, organisation and planning was more important to those who had previously had a big family to feed or were cooks by trade. For the single elderly, there was less of a need to plan and they were more inclined to eat what they felt like at the time. The exception to this was when people were entertaining guests. The planning was meticulous and may begin up to a week before the event. This habit, however, declined with age. The more elderly amongst them who felt their cooking skills would not stand the test of invitees reported to simply stop entertaining guests rather than try something a little simpler.

In Denmark, meals were rarely planned and decisions were made at the supermarket or from what was on offer advertised in the local weekly newspaper. Meals would be generally cooked everyday or use would be made of food stored in the freezer. People generally made lists. Inspiration came from magazine bargains advertised in local weekly papers and when shopping. It was felt by some that that it was difficult to come up with

inspirational ideas every day. This problem was also mentioned in Spain, particularly for those with families still at home, trying to vary meals every day and keeping everyone happy. Planning meals for the elderly in the UK was often based around what bargains were on offer and dictated what was on their shopping list.

For the elderly in Sweden, planning was done on a day-to-day basis. In many cases, shopping lists were written, but there was no detailed planning done. Several meals were often cooked at a time and stored in the freezer for a later date. It appeared that the older people were in many ways more organised than the younger generations as they had the time and could set aside a day for shopping and preparing of the meals for which they had bought ingredients. Sweden was the only country where respondents reported to have a certain day set aside for eating a certain food, in this case fish. Generally, the day the mobile fish van was in town dictated these.

3.3 Summary of Eating Habits and Meal Planning

Consistent throughout the five countries, it was reported that the majority of respondents ate three meals a day. These comprised breakfast, a main meal and a lighter meal.

For the elderly in Denmark and Sweden, the main meal of the day was reported to be taken either around the middle of the day or early evening, often depending on whether they lived in the city or country areas (Denmark) or their working situation (Sweden). In France and Spain, the majority reported to take their main meal at lunchtime. In contrast, the majority of those in the UK ate their main meal around 6pm, with the exception of some who ate their substantial Sunday meal at lunchtime.

The type of food consumed at breakfast was fairly consistent throughout, often including cereals, bread or toast, and yoghurt. Fruit or juice was often included, either at breakfast or for a mid-morning snack for some of the respondents. In the UK, Sweden and Denmark, breakfasts were reported to include a greater variety of foods than those in France and Spain.

For the main meal, the main differences reported between countries (apart from the time consumed) were the number of courses. In the UK and Denmark, the main meal was reported to consist usually of only one course. In Sweden and Spain, a three course meal (starter, main meal and dessert) was reported, and in France, a salad or cheese was often included as an additional course. For everyone, the main meal included meat or fish and vegetables in some form. Some of the Swedish elderly were the only ones reported to eat game. Consumption of fish appeared to be higher in Demark and Sweden, although it was reported in France and Spain that the main meal would include either meat or fish; the frequency of each was not mentioned. In the UK, fish was only reported to be eaten at lunch time in the form of (canned) tuna fish for sandwiches.

For the elderly in the UK and Denmark, the sandwich was a popular choice for the lighter meal of the day. Although served as an open sandwich in Denmark and closed in the UK, the fillings were reported to be similar, including either meat, egg or fish, often with salad vegetables. For the others, this meal may have included eggs or foods similar to the main meal, only in smaller quantities.

Snacking between meals was not reported to be a frequent occurrence. For the Spanish elderly, a morning snack ('Almuerzo') or mid afternoon snack ('Merienda') was reported to be taken by some. Sweet snacks such as cakes, pastries or confectionery were not recorded to be eaten, although the snacks eaten by the UK respondents at bedtime and those taken by the Swedish elderly with a cup of tea or coffee were not detailed.

Drinking water was reported to be particularly important for the elderly in Denmark. In France, respondents reported to drink water regularly with their main meal; however, habitual drinking of water was not reported in the other countries. With the exception of the French, alcohol was reported to be drunk fairly infrequently by the majority of respondents. Many of the French respondents, particularly the men, reported to enjoy beer and wine, which was more frequently consumed at the weekend.

In general, planning meals for the majority of respondents was done on a day-to-day basis and was less important for those living alone than those with more than one in the household. Weekly or even daily menus were rarely planned in advance with the exception of those preparing meals for guests and special occasions. This was true for most of the

European elderly, although the reasons dictating the lack of planning were not consistent throughout the countries. It appeared that the French elderly were more concerned with planning and organising food than those in other countries due to the deep-rooted culture revolving around mealtimes as social occasions. Sweden was the only country where it was reported that some of the elderly ate fish on a particular day.

4. PERCEIVED IMPORTANT INFLUENCES ON FOOD CHOICE

Many factors influenced food choice in the elderly respondents to a greater or lesser extent. Many were consistent in all countries and some were more country specific. The following section looks at the different factors and highlights differences and similarities between the five European countries.

4.1 Habit and Tradition

Habit and tradition influenced choice of food to some extent in all the countries.

The Danish respondents were reported to be influenced strongly by habit and tradition, particularly in the country areas. Methods of cooking and preparation were, for many, as they had always been. This was reflected in the fact that hardly anyone consumed ready meals, preferring the traditional approach of preparation from fresh ingredients. Few respondents had microwave ovens or other modern electrical appliances, most preferring traditional cooking methods.

In Sweden, it was reported that habit and tradition were the main factors influencing food choice. This was more marked in the older groups and among men. Thus, products such as rice and pasta not traditionally used in Swedish cooking were less favoured than potatoes. Convenience foods, such a ready meals, were not used to a great extent, despite ease of preparation, as tradition and habit had a greater influence.

For the French elderly, there was a strong influence of culinary tradition, which was definitely more pronounced in the rural locations. Those in the country tended to stick to traditional foods and habitually consumed the same meals. Traditional food such as salted butter, different sorts of cabbage and seafood products were consumed regularly by those living in the more rural areas of Nantes. Those living in Paris tended to be less traditional in their food choice and a greater variety of food was eaten. For all the elderly respondents, whether living in the city or country, ready meals were not purchased

frequently, neither were canned nor processed foods. A strong desire and a certain pride to be able to cook traditional, often sophisticated dishes, handed down though the generations (which would certainly not include pre-prepared or processed meals) was an important influence in the choice of food for the French elderly.

Similarly, in Spain a certain national pride was reported by the elderly in the consumption of their 'Mediterranean diet' and in particular their consumption of olive oil. Such a cultural and traditional product, originally used because of its abundance and availability, has remained a staple product in the Spanish cuisine. The diet, including the consumption of olive oil and lots of fruit and vegetables, although traditional in its roots, was regarded as the basis of a healthy diet and so the tradition has perpetuated. In Spain, the tradition for the family to congregate at the grandparents' home for socialising and eating was reported. Preparing meals for the family in a traditional way with fresh ingredients and manual skills was seen as a sign of health and quality, and was an important influence in food choice particularly, for these types of occasions.

In the UK, tradition played a lesser role in food choice. Unlike France and Spain, the culture of the UK does not revolve around preparation and eating of meals. Family eating occasions were less prevalent and even the traditional Sunday roast dinner for the family was not common amongst the respondents interviewed. Some UK respondents, however, reported to be driven quite strongly by habit, in that they would buy the same things and/or go to the same shops simply because they had always done so. This was however, not the main driving force for all, but usually for those who did not enjoy shopping and cooking.

Summary

It was clear that tradition was more of an influence in France and Spain where there was a certain pride in their countries' ability to cook and their custom of eating. For Sweden, Denmark and UK this was much less pronounced; however, traditional methods of cooking and preparing (i.e. without the use of electronic accessories) prevailed. Choice

was strongly driven by habit for many of the European elderly in as much as they tended towards buying and eating the same food.

4.2 Quality and Price

For most of the Danish respondents, prices were deemed to be less important than quality. The fact that smaller portions were needed and there were only one or two in the household meant that it was not difficult for most to afford good quality meat and vegetables. For those existing on a state pension alone it was suggested that it could be difficult to buy the best quality; however, very few respondents were in this sector. For the majority, an income was available to them in addition to the state pension and so price was less of an issue.

Food prices appeared to be considered reasonable to the Danish respondents. It was, however, often the case that meat was bought from the offers in magazines and in the supermarket although it was reported that it must be good quality or they would not buy it. Quality of vegetables was judged mainly on freshness and most bought fresh vegetables, although some frozen vegetables were consumed.

In general, price was not a restrictive influence for food purchase in Sweden and quality was reported to be more important than the price. Although no one had a strict budget, many were conscious of how much they could afford and an extravagant spend on food one day would be compensated for by spending less the next day or so. Any cost considerations mainly affected choice of meat product. Higher priced cuts were eaten at the weekends rather than during the week. It was felt that there was an over representation of respondents in the higher social brackets and a bias toward those more interested in food and willing to spend money on food. It was pointed out that, although not represented in this study, there did exist groups of elderly people in Sweden (particularly those on state pension) whose eating habits could be affected by their lack of financial resources.

Although price was reported not to be a big issue, those who could shopped at the larger stores where there was more selection and the prices were lower. The quality of products seemed to be the most important fact when deciding where to shop with the younger groups. Quality was seen mainly as 'freshness' of the product. Meat was especially seen as important. Good quality meat often determined where to shop. Purchase of quality fish was also important and the availability of fish in the mobile fish stores often dictated the shopping days.

For the British respondents, a different picture emerged relating to price and quality. Although for most of these elderly respondents, their financial situation had improved with their increase in age, for many, buying foods on offer and finding bargains was a strong influence on foods purchased. The availability of bargains and special offers often dictated where to shop and which products to buy and for some it justified their shopping trips. For most, it was for the pleasure of finding a bargain and the achievement of saving some money. This trait was reported more in those who were retired and had more time on their hands. Those in the oldest groups were not so keen on bargain hunting as they were often on their own and were less capable of carrying large quantities, so offers such as 'buy one, get one free' were less appealing.

As for most of the respondents in all countries, the definition of quality was often synonymous with freshness: buying fresh fruit and vegetables and not frozen ones, and not using processed food. In this respect, the bargain hunting culture was a stronger influence for many than quality. However, quality was also seen as a factor of food choice based on personal preference towards particular types of product such as organic, specialist products or environmentally friendly products. For such products some of the elderly perceived them as better quality and were therefore willing to pay higher prices. In a similar way, some of the elderly would buy certain brands perceived as better quality despite the slightly higher price. This was not, however, the main driving force for most of the British elderly.

For the French respondents, quality was reported to be the main influence in food choice. The quality of the product was judged by appearance and odour (e.g. for fish), country of origin, and presentation. Brand image played an important role in the selection of dry foodstuffs such as rice, pasta, coffee and chocolate. Top brand names were synonymous

with quality and many of the elderly chose those with a good reputation, regardless of price. Those with lower incomes, however, tried out cheaper brands and if they regarded the quality as good they would purchase those. Quality stamps on products such as chicken and ham were often viewed in a sceptical manner and not always taken as a sign of quality but more of a marketing device. Interest and credibility of quality stamps was more apparent among the urban younger age groups.

On a day-to-day basis, cost was not reported to have a great influence, and people bought what they felt like. However, cost was monitored to some extent and an extravagance one day would be counteracted by restrictions at a later date. Many worked to a monthly or weekly budget and those with more to spend, spent more on food. However, as mentioned above, quality for those on lower incomes was not compromised to a great extent. Many looked out for bargains and sales promotions, storing the excesses they acquired during these promotions to be used at a later date. Others would pay higher prices in order to obtain higher quality goods on the one hand, or because of the convenience aspect on the other. A food outlet in a more convenient location would, for some, justify paying a little more.

In Spain, it was reported that there was a division between those avid bargain hunters as seen in the UK and those that bought the foods they liked irrespective of the price. The concept of quality was mentioned regularly, particularly by the latter group, but was not always clearly defined. Again, quality often referred to the product's physical appearance. Similar to some of the French and UK respondents, a reputable known brand would be considered of higher quality and often purchased in preference to other brands.

Summary

The concept of quality for most of the European elderly was synonymous with freshness, lack of processing and cooking meals from first principles. Brand image influenced many whereas the product's physical appearance, odour, and presentation were only referred to by the French and the Spanish elderly. The quality of meat was often judged by the cut, and for some, better cuts would be bought at the weekend than during the week.

It was reported that for most of the respondents, quality was more important than price. This was a view perhaps most adamantly expressed by the French elderly. Conversely in the UK, very few expressed this sentiment. Although for most of the elderly cost did not seem to be a problem, there was a trait in many to look for bargains and to shop at stores where prices were lower. This was identified most specifically in some of the elderly from both the UK and Spain. It was reported that there were some bargain hunters in France; however, quality was not reported to be compromised to a large extent. For the French, it was reported that only those on lower incomes would try out less expensive brands; however, if they were not deemed suitable quality they would move to something more expensive.

Although cost was not reported to be a major issue, the elderly were aware of their weekly or monthly budget and would purchase accordingly. Extravagances one day would be counter balanced by more frugal purchases the next.

It was reported that there may have been an under representation of lower income elderly in Sweden. In Denmark, it was also mentioned that few respondents were in the lowest income groups. This may have biased the results when it came to quality and price and for those on very low incomes, price might be the most influential factor.

4.3 Shopping, Transportation and Convenience of Shops

Transportation and convenience of the shops were reported to be important within the elderly groups to some extent depending mainly on age group and mobility.

Most of the Swedish elderly had their own cars. Having a car was seen as very important and gave people the freedom to shop where they chose. For those without cars, food was transported home on buses, trams or on foot. It was reported that some, mainly the women, would use their bicycles for transportation of shopping.

Frequency of shopping increased with age mainly due to transportation problems. Those with cars tended to shop less frequently and did most of their shopping at supermarkets

and would travel some distance. Those without cars were limited to shops nearby or had to travel by bus or tram. In some places it was reported that finding a shop close by was difficult as the larger stores tended to be concentrated in one place and there were fewer smaller stores near residential areas.

It was reported that some, in the oldest groups, would like to get home delivery and would be willing to pay extra for this service. For the younger groups most were able and active, and transporting and handling the packaging was not a problem. Some of the eldest, however, were somewhat disabled and transportation of shopping had to be done with help.

Most of those in the younger age groups in Denmark, in the rural areas, had a car and would shop on average twice a week mainly in supermarkets. It was reported that around 40% had a car in the city (Copenhagen) and those without a car used bike or bus. In the older group where fewer had cars, shopping was carried out more or less every day. It was generally considered that having a car was important. Some respondents in Copenhagen said they would use a delivery service and would be prepared to pay more if one was available. One lady reported to get heavy things delivered to her door, although she reported it to be expensive. One married couple had meals delivered through the municipality 3-4 times a week.

For the elderly in the UK it was reported that from around the age of 75, convenience of shopping was critical in relation to transport and distance. To some extent it was reported that restrictions in the distance of the supermarket or the availability of public transport limited choice. The added expense of bus fares influenced the older respondent as to where to shop. For the younger elderly groups no problems with transport or location of store were reported.

Despite the problems for some with transportation, there was no call for home delivery among the elderly in the UK. This type of service was seen as more appropriate for people with busy working lives or for the house bound. It was important for the elderly in the UK to be able to do their own shopping and it was seen as something of an achievement. The fear of missing out on special offers or the social aspect of shopping was also a factor that deterred some from the home delivery option.

The majority of elderly respondents in France were still mobile (i.e. with their own cars) and so they had the freedom to shop where they chose. Many bought their food in hypermarkets in order to obtain a wide choice and better prices. Those living out of town would use independent smaller shops for their daily supplies and venture out to the supermarket about once a week.

For those without cars, shopping was not regarded as too much of a problem as public transport was used or they would walk to the shops using bags or shopping trolleys to transport their goods back home. For heavy items, many relied on their children to pick them up. Some living in the centre of Paris used a delivery service. Transportation and convenience of store was not reported to be particularly important to the French elderly.

In Spain, shopping for larger families (mainly the younger elderly groups) was usually done in supermarkets and hypermarkets. For those living alone, the men preferred to shop exclusively at supermarkets. On the other hand, women living alone tended to use fishmongers, butchers, and greengrocers or the market for fresh produce, and hypermarkets for other products. The reasons given for this were better quality and fresher products, as well as more personal attention. For the Spanish elderly, the frequency of shopping depended on the amount of free time available and the number of household members. Thus, the tendency of number of shopping trips to increase as age increased was seen. Generally the older the groups, the less likelihood of children being at home or the individual still being in full time employment. In the urban areas, as in Sweden, many complained about the disappearance of smaller local shops. In rural areas much of the shopping was done in these small local shops. Transportation did not appear to be a problem for those shopping in Spain even though only the men in the youngest groups used cars for shopping. The rest reported to go shopping most of the time on foot with only the occasional use of public transport. For those in the oldest group who had problems with mobility or ability to carry, home delivery was used or relatives and children would help out.

Summary

In general for the younger elderly and those with transport of their own, shopping, transportation and convenience of store did not have a great influence on choice. Being mobile meant there were no limitations as to where to go shopping and so respondents in these groups were free to shop where they chose.

For those in Spain and France, increasing age or lack of personal transport were reported as problems. Shopping was carried out on foot or local transport or family members would assist. Home delivery was an option taken by several who had mobility problems.

In Denmark and Sweden, the importance of being mobile was strongly highlighted. Those without transport were limited to shopping at stores nearby and so to some extent this affected their purchases. Limitations were seen when elderly persons were unable to drive to the shops. It was reported that home delivery service would be useful to those in Denmark and Sweden, although only one of the respondents reported to utilise such a service at the time of the study.

In the UK for the older groups, the convenience of the store and the availability and expense of public transport was reported to limit choice. There was no call, however, for home delivery service among the UK respondents. The attitude was that it was suitable for younger people who didn't have any time to shop. For the elderly it was important for them to do their own shopping. Home delivery was seen as a loss of independence and so not acceptable.

Within the countries studied only one couple in Denmark reported to have meals delivered through the social services on a regular basis.

4.4 Ease of Preparation

Despite the length of preparation, the majority preferred to cook meals from scratch with fresh ingredients. Convenience products were not reported to be used to any great extent by most of the respondents, with the exception of certain groups and particularly for those in the UK.

In Sweden it was slightly more common amongst those living alone to use ready prepared products, and for others it was more common at specific occasions such as holidays. Ready meals were considered to be lacking in flavour and too small for some of the Swedish men.

In Spain only men living alone consumed convenience foods and ready meals. Similarly for Spain and Denmark, there was a reticence towards the use of both prepared meals and electrical equipment to aid convenience and ease of preparation. Microwave ovens were not used to a great extent by any of the elderly groups. However, for those living alone, in particularly the men, frozen foods were often used.

For the French elderly, canned food was only an occasional purchase for all groups. Frozen vegetables were seen as second best to fresh vegetables and used only occasionally. The middle age groups, exclusively in the urban areas, the younger groups preferring to prepare meals themselves and the oldest groups not satisfied with the quality, reportedly only bought ready meals.

For the UK elderly, particularly in the oldest age groups and men, many relied on ready-made meals. For all groups there was reported to be a general trend towards convenience foods. In the younger groups the use of such products, which need little preparation, were related to an active way of life. Preparation time of meals was reduced to make more time to pursue other activities and hobbies.

Summary

The European elderly, with the exception of those in the UK, generally did not consume convenience foods. For many, the quality of a meal was determined by the freshness of the ingredients and the preparation from raw materials. Thus, buying processed foods or ready meals was not considered for this reason. For some men living alone, the use of processed foods and ready meals (particularly in the UK) was reported to be higher than in other groups. However, in general, convenience was not a major factor influencing the majority in France, Spain, Denmark and Sweden

In the UK, convenience products were reported to play quite a major role in food choice for elderly of all age groups. For the younger elderly groups, the use of convenience foods was reported to give more time to pursue other activities. For the older groups, particularly the men living alone, there was reported to be a heavy reliance on ready meals.

4.5 Portion/Pack Size

Portion size was generally not reported to have a strong influence on food choice, although specific products were mentioned in relation to problems with portion size.

In Denmark, most respondents were reported to be able to adapt to pack size by cooking two or three meals at one time and freezing them for a later date. Only for a small minority of single elderly was pack size seen as a problem. One lady was reported to have bought frozen vegetables as they were often easy to divide into portions.

Similarly for the UK elderly, buying fresh vegetables such as cauliflower, cabbage or cucumber was often not feasible for those living alone as the size was too big.

In Sweden, the only problem mentioned (by a few respondents) was that all pre-packed hard cheese came in too large pack sizes to suit single-person households. Smaller pieces

could be purchased over the counter at the right size, but at a higher price. For the majority of the Swedish, the extensive use of freezers counteracted any problems they had with large pack sizes.

For the younger groups of the French elderly, portion size was not a problem and they would adapt their meals around the amount of food bought. For the older groups, it was perhaps more of a problem and they tended to believe that packaging was in favour of larger families, with some of the things they would like to buy available only in large quantities. For those with higher incomes, the higher prices of smaller packets did not deter them from buying them.

In Spain, it was generally thought that there was a sufficient variety of packaging sizes to cover all needs. The size of the pack bought often depended on the number of persons in the household. However, many of the Spanish elderly preferred to buy larger packs because it was more economical.

Summary

Package and portion size was not reported to be a major influence in food choice for the majority of the European elderly, for the majority of food items. Many of the elderly would utilise large portion and pack size for economical reasons and would prepare several meals at once.

Only for the single and older elderly was it reported that larger packages could be a problem, either because smaller packages were not available or they were more expensive. The size of some fresh vegetables, including cauliflower and cabbage, was reported to restrict the purchase by some of the UK elderly, as they were too big to be used.

4.6 Packaging

Problems with packaging were infrequently mentioned by the majority of the respondents. The main problem with handling packaging was transportation problems rather than physical problems with opening packets.

When discussing packaging, the French elderly groups were more concerned with the wastefulness of it all and were in favour of recycling. They did, however, report that they noticed if the packaging made the product more convenient to carry.

The main problem with the packaging for the Spanish elderly concerned large products such as bottled water, which was deemed difficult to carry although difficulty in opening some packets was reported by one man.

In Sweden it was reported that bringing home, opening, handling and storing packs were not problems for any of the elderly groups. In Denmark and the UK there were no problems reported with packaging.

Summary

Packaging was not reported to be a problem to any extent among the elderly from all the European countries. Packaging that enabled ease of carrying may have influenced choice to some extent for heavier items such as bottled water. Difficulties with opening packs were reported only rarely and did not appear to influence choice to any extent.

4.7 Nutritional and Health Aspects

From a nutritional point of view, the Danish respondents were most concerned with fat content and for many the 'healthiness' of the food was related to the amount of fat in it.

They would often buy lower fat alternatives. Many, particularly in the younger groups, were also concerned with E numbers, and this may have affected choice.

Most Swedish respondents reported that they believed it was important to vary meals and include all the important nutrients. It was reported that there was little awareness among the Swedish elderly of the direct influence that food may have on health. However, it was believed to be important to eat a lot of vegetables and that offal was not consumed as often as it used to be, as it was not considered as 'healthy'. Thus, to some extent the health aspect influenced their choice.

For the UK respondents, nutrition concerns regarding the food they consumed were related mainly to fat, sugar and calorific content of the food. Fat and sugar contents on the labelling influenced the decision to choose products, particularly sauces, mayonnaise, yoghurt, milk, margarine and ready meals. The reasons for this were mainly medical and concerns with weight. Organic food and control of preservatives were occasionally linked with healthy eating and, for some, affected choice.

In Spain, the general 'Mediterranean' diet with plenty of vegetables and fruit and the use of olive oil was considered to be healthy and so no specific nutritional aspects were reported as factors influencing food choice. However, when investigating dietary change it was reported by many that for health reasons, sugar and foods that increased cholesterol were avoided.

The strong culinary tradition of appreciating quality and enjoying food meant that nutritional aspects were little considered by the majority of French elderly when purchasing food and cooking meals. For the very elderly or those who needed to lose weight for medical or aesthetic purposes, there was a little more concern for the health aspect of their diet. This, however, was seen only in the minority of cases. For some, restrictions on their diet recommended by their doctors were reported to limit choice (e.g. low salt diet).

Summary

The nutritional aspect of food influenced to some extent food choice for many of the elderly. For most, the 'healthiness' of the food related to the amount of fat in it and to a lesser extent the amount of sugar. For some respondents, the main nutritional influence came from the desire to lose weight for medical or personal reasons, or because of illness and consequent dietary recommendations from a doctor.

Very few respondents in France considered the health aspect of food as an influential factor of choice. It appeared that the stronger the cultural influence, the less the nutritional aspects of food influenced food choice.

4.8 Location

The choice of location of the study within each country influenced choice to some extent for a variety of reasons.

In Sweden, the study was carried out in Gothenberg, close to the coast. It was suggested that fish consumption in this area might have been higher than for other parts of Sweden due to the availability and proximity of fresh supplies.

In Spain, the location had a strong influence on the typical main meal of the day. The region in which the respondents lived dictated to a large extent the dish to be prepared. For example the most common dish in Valencia was paella and that in Madrid was stew.

Differences between rural and urban locations were seen to some extent and were most marked in France. Those living in rural areas ate more traditional and regional dishes and less varied food than those living in Paris. Differences between rural and city locations were not reported to such an extent in the other countries investigated. This may have been due to the fact that group discussions and depth interviews did not take place in two completely distinct areas such as in France. It was mentioned in Denmark, however, that

residents of the rural areas reportedly enjoyed their food more than those living in the city, although this did not appear to have a marked effect on food choice, more an influence on attitude towards food.

Summary

The location chosen for the studies in each of the countries was important in as much as that this in itself in some cases had an influence over food choice. Availability of certain produce (e.g. fish in Sweden) may have influenced eating habits in that particular area more than in other areas of the country.

Differences between city and rural locations were seen most markedly with the French respondents, and the region in which respondents lived in Spain had a fairly strong influence on choice. In the UK and Denmark, the location reportedly had little influence on choice of food.

5. MAIN PERCEIVED BARRIERS TO EATING A HEALTHY DIET

5.1 Perceived Barriers within Each Country

The perceived barriers to a healthy diet largely depended on perception, interpretation and attitudes towards a healthy diet and food in general.

Denmark

For the elderly in Denmark, one of the main perceptions of a healthy diet was drinking lots of water. Most respondents were aware that they should be drinking 2 litres a day and felt guilty if they did not. This information, supplied by doctors and in health magazines or weekly TV programmes, seemed to cause a certain amount of guilt among the respondents if they couldn't manage to drink this amount. Many of the elderly simply did not feel thirsty and so could not drink this amount of liquid, and some were uncertain about whether tea and coffee should be included in their liquid requirement.

Many respondents expressed a concern over E numbers, although it was revealed that their understanding was limited, and it was reported that more information would be appreciated. It was also reported that they would like to know more about food additives. Generally, lack of information appeared to be a barrier to knowledge of various aspects of food related to health, and so could be perceived as a barrier to a healthy diet. It was reported that the elderly in Denmark would like to see knowledge of shopkeepers increased, in as much as they could offer more information about the products they were selling. There was also a desire for more easily readable and understandable information about ingredients and nutritional labelling on the products or in the shop.

For those who were single, it was reported that it was easy to skip meals when eating alone. This is generally considered not to be a healthy eating practice and removing the social aspect of eating for many had a big effect on eating habits and in this respect may be a barrier to healthy eating.

Sweden

In Sweden, healthy eating was understood by most of the elderly respondents to include varying meals, avoiding too much fat, eating at regular times and reasonably well and making food enjoyable. Many respondents agreed that eating habits affected health status, but only when dietary habits were extremely bad. Less was understood about the positive health benefits of choosing the right food. Healthy eating was seen as uncomplicated, with variety believed to be important in order to include the basic nutrients. However, eating food simply because it was healthy and denying oneself the enjoyment of eating was regarded by the Swedish elderly as more harmful than maintaining a reasonably healthy diet, but enjoying what you ate.

More people were concerned with the negative health aspects and the implications of the many food scares that had occurred in the last decades including BSE, *Salmonella*, mercury in fish and heavy metals in mushrooms. Although these may have influenced food choice to a small extent, they were not restrictions to a healthy diet. The attitude of the Swedish elderly was that it was more important for younger people not to accrue such harmful substances in their bodies and it did not matter so much for them in their old age.

In addition, most of the Swedish believed they were eating healthier today than they were 20-30 years ago in that they ate more vegetables and less fat. Thus, there seemed to be no room for improvement. The elderly did not perceive any problems in maintaining a healthy diet. They believed a healthy regime was uncomplicated and something they were already following. There was, however, some underlying conflict between taste and health aspects. The elderly generally reported that they had reduced the amount of butter and cream as a reflection of general attitudes towards a reduction in fat for a healthier life style. They still believed, however, that these ingredients enhanced the taste of their food. This was not seen as a huge sacrifice as it was reported that many used the weekends to indulge in tasty rather than healthy food.

Physical and social activities were seen as important for well being. Finding better health through eating was not the top priority and the elderly group believed that living a normal, active and happy life as possible was more important.

It was reported by the Swedish elderly that information was widely available and sources included newspapers, TV, magazines, doctors, organisations for the elderly and cooking literature. The majority did not feel that they lacked knowledge. However, they were wary of the fact that opinions of healthy products and health messages tended to change fairly rapidly. Thus, they were often ignored.

United Kingdom

For the elderly in the UK, it was not generally financial, physical or practical barriers that came between the elderly and a healthy diet but attitudes towards change and perception of their diet. However, there were one or two aspects unrelated to attitude that it is important to mention.

One practical aspect that could be perceived as a barrier to a healthy diet was related to the size of some fresh vegetables. Some of the elderly (particularly the single) complained that vegetables such as cabbage and cauliflower were too big for them to use. Thus, this reduced their choice of fresh vegetables and so could be perceived as a barrier to a healthy diet.

Several of the elderly in the UK suffered from arthritis, and thus it was reported to limit such activities as the carrying of bags, peeling of vegetables and lifting of pans. This obviously limits the use of some fresh vegetables and some cooking procedures, which therefore could be perceived as a barrier to a healthy diet.

Other barriers to a healthy diet were based on the attitudes of the elderly in the UK. It was reported that there was a division between those who already considered themselves as healthy eaters, those who did not really care about healthy eating and those who believed there was room for improvement in their diet.

Most of the elderly respondents considered that they already had a healthy diet and so did not consider any changes were needed. Some of these appeared to be open to change but were not sure how they could improve their diet. They reported to have already changed to a healthier regime including eating more salad and cutting down on fat and sugar. They

were interested in a healthy diet yet lacked ideas on how to make further changes. Others, who also believed they had a healthy diet, had a different attitude and were not open to new ideas and changes. This group were sceptical of new health messages and criticised information as confusing. These respondents were wary that health messages were often merely used as an advertising ploy and they were not convinced by the validity of the claims.

Some of the elderly respondents reported to be not particularly bothered about healthy eating and were not interested in changing their diet. Some of these believed that they were happy and felt well, eating as they had always eaten and felt there was no use in changing at this stage in their life. Others were simply disinterested and would be open to change if their awareness and interest were raised.

The third group of people identified among the UK elderly respondents were those who knew they were not eating particularly healthily but had their own reasons for not being able to improve. Some felt that they were reducing enjoyment of food, for example, by cutting down on fat. The temptations of foods such as chips were often too great, even though attempts were made to cut down. For couples this was reported to be more of a problem. Some of the women were often swayed by what their husbands preferred and reported to either have to cook separately for themselves or simply give in to the temptation. For others who were not eating particularly healthily, their attitude was that they saw no use in cutting out the things they enjoyed and did not want further restrictions to the pleasures they had left in life.

For many of the UK elderly, weight concerns were linked with healthy eating. There appeared to be a lack of knowledge regarding diet and health and this was linked to a lack of relevant, interesting and possibly more scientific information to convey these messages clearly.

France

In France, one of the main barriers to a healthy diet was the very strong influence of culinary tradition. The French elderly were reported to be proud of their culture of which the ability to cook fine foods and enjoy the social aspects of eating meals was a large part. Rich, sophisticated dishes were prepared as they had been for generations. The majority of the French did not concern themselves with the health aspects of eating and tradition had a strong hold.

The French elderly gained great pleasure and satisfaction from eating and for many of the elderly, eating healthy foods represented lack of taste and reduction in enjoyment. For those whose other senses were failing, such as sight and hearing, the pleasures of eating were not so easily given up. It was only in the very oldest groups that a progressive decline in the eating of traditional meals was observed. In this age group there tended to be a more positive attitude towards healthy eating with some experience of low fat products. However, even in this age group, food eaten generally remained similar to how it had always been, just smaller in quantity.

The French elderly respondents did not report there was a lack of information. On the contrary too much information, which was often contradictory, regarding healthy eating made them sceptical of health messages and prone to ignoring much of what they heard or read about. As a consequence, a general lack of understanding of what comprises a healthy diet was a barrier for some of the French respondents. The perception of healthy eating was often confused with the number of calories eaten or slimming diets.

Although it was not reported that they believed they already had a healthy diet, many assumed that many of the foods they were eating were essential to maintain health. Examples of this were given as vitamins and calcium in butter and dairy products, and a glass of red wine per day.

In general, healthy eating tended to have more of a negative image than a positive one. To many, healthy eating implied loss of taste, insufficient quantity, loss of enjoyment in eating and so was restrictive in many ways. This perception of a healthy diet and the strong traditional culture were the major barriers to healthy eating for the French elderly.

Spain

In Spain, the barriers to a healthy diet were again mainly to do with interpretation and understanding of what comprises such a regime. One practical aspect that was mentioned, however, was the consumption of fish. This was reported to be quite high in the elderly groups from Spain. For some, the bones caused some reticence to eat fish and thus a barrier to eating this healthy and nutritious food.

One of the main barriers for the elderly in Spain was the fact that they already believed that their traditional Mediterranean diet was healthy. The preparation of fresh foods as opposed to convenience foods was particularly seen as important for a healthy diet, and the use of olive oil and lots of vegetables and fruits contributed to this.

For the elderly in Spain, similar to in France, the preparation and enjoyment of food was seen as part of their culture. In such a culture the enjoyment of food for many was more important than the health aspect. The fact that the Spanish elderly preferred to enjoy their food rather than what they regarded as restraining themselves and eating more healthily, was again a barrier to healthier eating.

In some ways there was contradictory message emanating from the elderly in Spain. On the one hand the majority reported to believe that what they had always eaten was healthy; on the other, they believed that healthy food or food prepared in a healthy way did not taste as good. Thus, the image of their own diet as being healthy and enjoyable did not coincide with their image of healthy foods. This was also true to some extent for many of the elderly in other countries.

The elderly in Spain did not complain of lack of information on healthy eating but made it clear that the most important influential messages on diet came from doctors. Lack of trust of messages on the TV or in the press were apparent. Labels were also reported not to be trusted by some and not utilised by many because the print was often complicated and too small.

Although the concept of healthy eating was fairly subjective, confusion between weight concerns and a healthy diet were not reported from the group of Spanish elderly.

5.2 Summary of Barriers to a Healthy Diet

The main barriers to a healthy diet in all countries depended on perception, understanding and attitude to a healthy diet. Although these perceptions within and between countries were by no means completely homogenous, there were several barriers to healthy eating which were common throughout.

Common to all countries was the fact that many perceived themselves as having a healthy diet and so did not see reason for change. The majority perceived that they were eating a healthy diet either because it was synonymous with the diet of their country and they had always eaten that way (Spain) or eating habits had moved toward being more healthy following general trends and attitudes. The French elderly, although not reporting that they perceived their diet as healthy, believed that many of the things they were eating were essential to maintain good health (e.g. cheese and dairy products).

A lack of understanding of the benefits of healthy eating and confusion between healthy eating and weight loss regimes could also be construed as a barrier for many of the European elderly. For many respondents in all countries, the perceived negative aspects of eating some foods outweighed the perceived benefits of healthy foods. This did not appear to stem from lack of information which was reported to be received in abundance for most from various sources including magazines, health programmes, on the television and doctors' advice. However, there was a certain attitude of mistrust (with the exception of advice from the doctor) of information regarding healthy food due to the fact that there was so much information, which was often contradictory in nature.

The fact that healthy food was perceived as less tasty and enjoyable was also seen across all cultures regardless of whether they perceived their own diet as being healthy or not. Thus such negative expectations of healthy food provide a strong barrier to healthy eating for many.

Contrasting attitudes proved barriers to healthy eating in France and the UK. For many of the French elderly, the strong passion for food, deep rooted in its culture, was a strong barrier to eating a more healthy diet. Traditional rich dishes, made as they always had been, were unlikely to be open to adaptation to make them healthier. Conversely for many of the UK elderly, an altogether different relationship with food and often the lack of interest led to barriers of a different kind. The lack of inspiration, motivation and interest provided this 'not bothered' attitude for some of the UK elderly respondents.

The attitude that it was not worth worrying about food eaten in later years was also prevalent among the elderly. Many had the opinion that it is much more important to eat the right foods when you are young and that it really was not going to make much difference in old age.

There were very few physical, physiological or practical problems that were reported, which could be perceived as barriers to a healthy diet. Practical problems with implications of being barriers to a healthy diet including the purchase of some fresh vegetables (too large for one person) and the dislike of fish bones which were mentioned by the elderly in the UK and Spain respectively. The physical problem of arthritis was mentioned by some UK respondents, which inevitably meant reduced ability to handle utensils and prepare fresh produce and so was a potential barrier to healthy eating.

In Denmark there was much emphasis on drinking water as a healthy practice. Physiological barriers, including lack of thirst, prevented many from doing so. A lack of understanding as to what liquids were included in the daily-recommended intake caused confusion as to how much many of them were actually drinking.

Financial aspects were hardly mentioned as a barrier to eating healthily by any of the elderly.

6. DIETARY CHANGE

6.1 Dietary Change within Each Country

Several changes were reported to have occurred in the diet of the elderly respondents. Very few of these changes, however, were reported as a result of physical and physiological changes that accompany old age. Changes that occurred were often related to life changes associated with ageing, although often referred to as being independent of the ageing process.

Denmark

Many in the younger groups in Denmark claimed not to have changed their eating habits in recent years. Those in early retirement, however, had become aware of food quality and were more interested in trying something new. Some admitted a change from traditional Danish foods to more exotic and spicy food. In this group it was also noted that an increase of homegrown produce had taken place, possibly due to more time being spent in the garden.

Several reported to be eating less fat and checking labels regarding fat content more closely. This was reported to come about as a gradual, almost subconscious awareness of the need to lower fat in the diet. There was a general decrease in using gravy with meals and a tendency for the size of meals to reduce with age. The Danish elderly also reported that they drank more water than they used to.

For the older elderly, dietary change was made, for some, under the advice of the doctor because of an illness or from pressure from children who suggested a healthier regime. It appeared that for the Danish elderly, the majority of changes towards a healthier diet took place in the oldest age groups.

Sweden

Dietary change in Sweden was reported to be mainly independent of the ageing process with most of the changes reflecting those general to Swedish society.

Changes reported to reflect attitudes towards healthy eating in all ages in Sweden included eating more fruit and vegetables, more fibre (e.g. wholemeal bread), less fatty foods, less offal, and less cream and butter. Offal (e.g. liver, kidneys and sweetbreads) was not consumed as often as it used to be, as it was no longer perceived to be 'healthy'.

The only clear, age–dependent change was reported to be to be smaller portions and lighter meals. Portion sizes decreased with increase in age. The reasons reported for this change in eating habits were; that weight was put on more easily and a reduction in physical work with increasing age.

Important transitions in life, not altogether independent of age, had an impact on eating habits. Such changes included losing a partner, retiring, sickness of oneself or partner, or children leaving home.

Children tended to dictate to some extent the choice of food, particularly in the younger age groups where it was not unusual for children to still be living at home. Once the children had left, the parents could choose just what they wanted with a bigger budget, as there was less food to buy. Many had reduced intake of pasta, for example, which they had eaten when the children were living at home, but was not their favourite choice now they had left. However, it was reported that those who enjoyed pasta ate more than they used to. Changes toward better quality food, such as better cuts of meat, were reported to be due to the fact that quality foods were more affordable once the family had left home.

Retirement influenced the roles that the male partner played in relation to food and also in some cases a change of meal times.

The loss of a partner took away the social aspect and therefore much of the pleasure of preparing, cooking and eating. The practical aspects were more problematic for the men

who had not been used to preparing meals for themselves. Although it was reported that many learned to cope with this, the lack of social context remained.

Illness affecting one person in the household generally affected the food that everyone in the household ate. There were a few dietary changes, which involved acute medical problems that required special diets. A few reported to suffer from obesity, diabetes and cardiac problems, which had instigated dietary change.

United Kingdom

For the elderly respondents in the UK, the most common changes that occurred were eating less, and eating fewer fatty products, fried foods and red meat and less sugar. Also reported were eating earlier than previously, eating more ready-made meals and eating less of the traditional Sunday dinners.

Dietary changes were often linked with life stage events that accompany ageing. Not all the changes reported were motivated by an attempt to eat more healthily. Different life stages, including children leaving home, retirement, loss of partner and illness, were reported to alter eating habits mainly in the direction of convenience foods and not specifically towards a healthy diet.

When children left home, certain foods were not consumed any more. Making pies and other home baked produce, for example, was reported to have been stopped by some.

Retirement gave people more time to cook and shop which for some, particularly those in couples, made shopping and cooking more pleasurable. For others (mainly single people), it was not so. For men retiring, the change was usually greater and they tended to play a much bigger role in the shopping and cooking and some would often experiment with new dishes such as pasta or curries. Thus, for these couples dietary changes towards more variety were made after retirement. There was also an increase in the consumption of ready meals reported by those who led very active and busy lives in their retirement.

When an elderly person became single (after divorce or death of spouse), dietary change was seen. Females tended not to cook as much as they had done and ate less, and males tended to eat out or eat ready meals. The enthusiasm for cooking was reported to wane when people were left on their own.

Medical conditions such as high blood pressure, high cholesterol, heart attacks and digestive problems explained sudden changes in the diets of some of the elderly. It was reported that women looked upon healthy food in a preventative way and tried to implement changes that would avoid such problems in the future. For the men this was generally not so.

The transportation, preparation and cooking of fresh foods was hampered in some cases by the severity of arthritis and for some this meant dietary change to more convenient methods.

For the UK elderly, losing weight for either health or aesthetic reasons was a motivation to change their diet and eat healthier foods. However, some knew themselves to be overweight, but had the opinion that at a certain age diets did not work and any extra weight was there to stay. A few were reported to have convinced themselves that weight was not important in old age.

Ageing was associated with diminished appetite and increasing problems with certain types of foods. For a few, particularly in the oldest age group, it was a question of maintaining weight and getting enough nutrients when appetite was low. Some physical changes were reported such as mechanical difficulties with chewing and diminished sense of taste, which contributed to the loss of interest in food. Many elderly had given up stodgy greasy food and alcohol, and moved towards a healthier diet to prevent digestive and other problems occurring.

Changes were more clearly seen for women or when a woman influenced a partner's eating habits.

France

In France it was reported that there was resistance to both admitting to and actually instigating dietary change. For many, if they felt good in themselves, then they felt there was no reason to change their diet.

In the older groups, the elderly reported to be eating much the same as they had always eaten, just a little less. It was reported, however, that some amongst oldest groups had the most positive attitude towards a healthy diet and had made some changes towards low fat products and drinking herbal teas. However, food consumption remained generally as it had always been, just smaller quantities.

For the French elderly, changes in diet were mainly linked to life events such as the children leaving home or retirement. When children left home changes in the quality of ingredients and refinements of dishes were made, as there was less cooking based on sustaining dishes for the family.

To a lesser extent, death of spouse was reported to change eating habits. This did not deter the French elderly from cooking, but the meals produced were simple and quickly prepared. For widowed men, many learnt simple recipes and used ready prepared meals.

For a few, particularly the women under 75 years old, weight problems and the desire to remain slim were reported as an influence to dietary change. For the majority of the French elderly there was, however, little mention of giving up fat or sugar or moving towards a healthier diet.

For a few exceptional cases, diet had changed as a result of illness, following doctors' advice. However, for many, particularly the younger group, even advice from the doctor was not taken too seriously. Following doctors' dietary recommendations often came only after serious illness necessitated dietary change in order to stay alive.

For the younger elderly, increase in variety and availability of products on the market was reported to allow them to eat a greater variety than they used to.

Spain

In Spain, changes in diet were reported to have been made mainly for health reasons. However, the underlying influence of certain life events was noted.

The main changes reported were the avoidance of sugar and foods which increased cholesterol levels (i.e. less animal fat consumed). Less food was reportedly eaten and the food was lighter. The main reasons reported for these changes were for better health and because of lower energy requirements. For many there had been a change towards an increase in fruit and vegetables and fish and decrease in red meat consumption. For some, however, fish was eaten less, because of the bones.

It was reported that the women were more concerned and had undergone more dietary change than the men.

For those who still had families living at home it was reported that less change had occurred. Some of the Spanish elderly (generally those living alone) reported that they had lost all their appetite and so ate less than they used to.

Although illness or physiological problems were not reported by the elderly in Spain, some changes which were reported, for example, a reduction in highly flavoured foods, spices and strong drinks, may have been due to digestive disorders.

6.2 Summary of Dietary Change

For many of the European elderly, dietary change was reported. The extent and the type of change that occurred depended on several factors. Many of the changes were associated with lifestage changes relating to age such as retirement, children leaving home, loss of a partner and illness. These changes were fairly consistent throughout the 5 countries.

Dietary change for the younger elderly, and particularly those who had recently retired often brought about changes towards more variety and innovation as there was more time to shop and prepare. This was linked with the increased variety of food available.

For many, when the children left home this meant the elderly were free to eat what they wanted. Linked to this was the financial aspect of food being more affordable when only buying for one or two and so it was often reported that better quality food was purchased.

Loss of a partner was reported to bring about dietary change. For some, the social aspect of eating had gone and so interest in food preparation and cooking had been lost and appetite diminished.

Apart from in Spain where illness was not mentioned, it was clear that dietary change for some had been instigated by the onset of an illness or medical condition following recommendations from the doctor. Heart problems, digestive disorders and blood pressure were among those illnesses mentioned which had brought about change towards a healthier regime.

Weight problems were also reported to have been one of the reasons for a change in diet and the move towards a healthier way of eating.

There was a certain reticence to admitting dietary change, particularly towards a healthier diet. This was seen particularly with the French elderly. Although many of the elderly throughout the countries perceived that they had not changed their diet, the French elderly reported the least changes. Whereas in the other countries, many of the elderly experienced dietary change in a more healthy direction, this was not so for the French. It was reported that only in the eldest group was diet moving, for a few of them, towards a healthier regime.

Changes towards a more healthy diet included lowering of fat and sugar and fried foods and an increase in fibre and fruit and vegetables. This was reported either to have occurred gradually as a natural trend seen throughout the population, or inspired by family or as an effort to improve health or help to reduce weight. These changes towards a healthy diet were reported to be more apparent in women than in men.

One of the main changes consistent throughout the European elderly was a reduction in the amount eaten. Portion sizes were reported to decrease with age, the main reasons being a lowering of physical activity and an increase in tendency to put on weight.

Physical and physiological problems were not reported to a large extent to have evoked dietary change. In the UK, problems with teeth, digestive disorders and arthritis were reported by a small minority to have forced some changes in diet to occur. For some of the UK elderly, it was reported that there was a reticence to admit changes caused by this type of problem. This reticence may have been extended in other countries, explaining partly why problems such as these were not mentioned.

7. ATTITUDES TOWARDS FOOD

7.1 Attitudes towards Food within Each Country

Within any population attitudes vary, and the European elderly's attitudes towards food were no exception. It was reported in all countries that attitudes towards food were divided. Although it was not a simple matter of dividing the respondents for each country into those 'eating to live' and those 'living to eat' it was clear that there were groups common to all countries which did in fact fall within, or somewhere between, these two divides.

Denmark

It was reported that the attitudes of Danish elderly were divided into three main categories:

those that did not like to cook and just ate because it was necessary;
those that did not like to cook, but did like to eat;
and those who liked to cook and eat.

The majority of those in the youngest age group were found in the latter category. Some, however, did not enjoy cooking and this was reported mainly to be due to boredom and lack of motivation. For these respondents, cooking for visitors provided the interest and motivation and most did not mind spending more time, rising to the challenge, and enjoyed cooking for guests.

Those who did not enjoy cooking and ate only because it was necessary tended to increase in number in the oldest age groups. Preparation and cooking for the very elderly was often seen as exhausting and something that merely had to be done in order to eat.

It was apparent that attitudes were often different between those who still lived with partners and those living alone. Although some of the single elderly had adjusted well to

being on their own, for others the pleasure of eating and cooking had disappeared. Nevertheless, for all, dining with others brought much more enjoyment to the occasion for all respondents.

There was a difference reported between the participants in the city groups and those in more rural areas. In the rural areas, the elderly were reported to enjoy eating their food more than those in the city. Although there were more couples than single people in this group, which could have contributed to this apparent increase in enjoyment, it was noted that the single people in the rural areas also had a positive attitude to preparing and eating food.

Sweden

In Sweden, most of the elderly respondents agreed that food was an important ingredient for leading a healthy and active life. The pleasure of cooking and eating, together with the social aspects, were reasons for the majority of the Swedish elderly respondents to harbour a positive attitude towards food. However, attitudes to food were divided and different groups were identified and summarised in the following categories:

those who enjoyed cooking;
those who liked to eat good food, but were not so keen on cooking;
those who centred on the social aspects of the meals;
and those who found eating /cooking to be just an everyday chore.

For the Swedish elderly, the most marked difference in attitude was reported to be between those living alone and those still living as a couple. For many people who were living alone, food was regarded merely as a means of survival whereas those living with their partner appreciated the pleasures and enjoyed it much more. Many single people found food less important or not important at all. In particular, the single males saw eating food as a necessity only and were concentrated in the latter group. For many men, still living with their wives, however, retirement provided new opportunities and an increased interest and enjoyment and so positive attitude towards food.

The weekends were highlighted as more important for the Swedish elderly, with better food and longer time preparing food for those belonging to the first three groups mentioned above. Single people, however, did not differentiate in this way.

United Kingdom

In the UK, elderly people's attitudes towards food were defined over two axes, one pertaining to the pleasure derived from food and the other illustrating the effort people were willing to make (see Figure 1). This led to five different profiles of attitudes associated with different characteristics of people. As the elderly often positioned themselves in reference to their children or to young people in general, the category of 'young people' denoted their position in the eyes of the elderly respondents.

Figure 1: Consumer profile – Attitudes towards food.

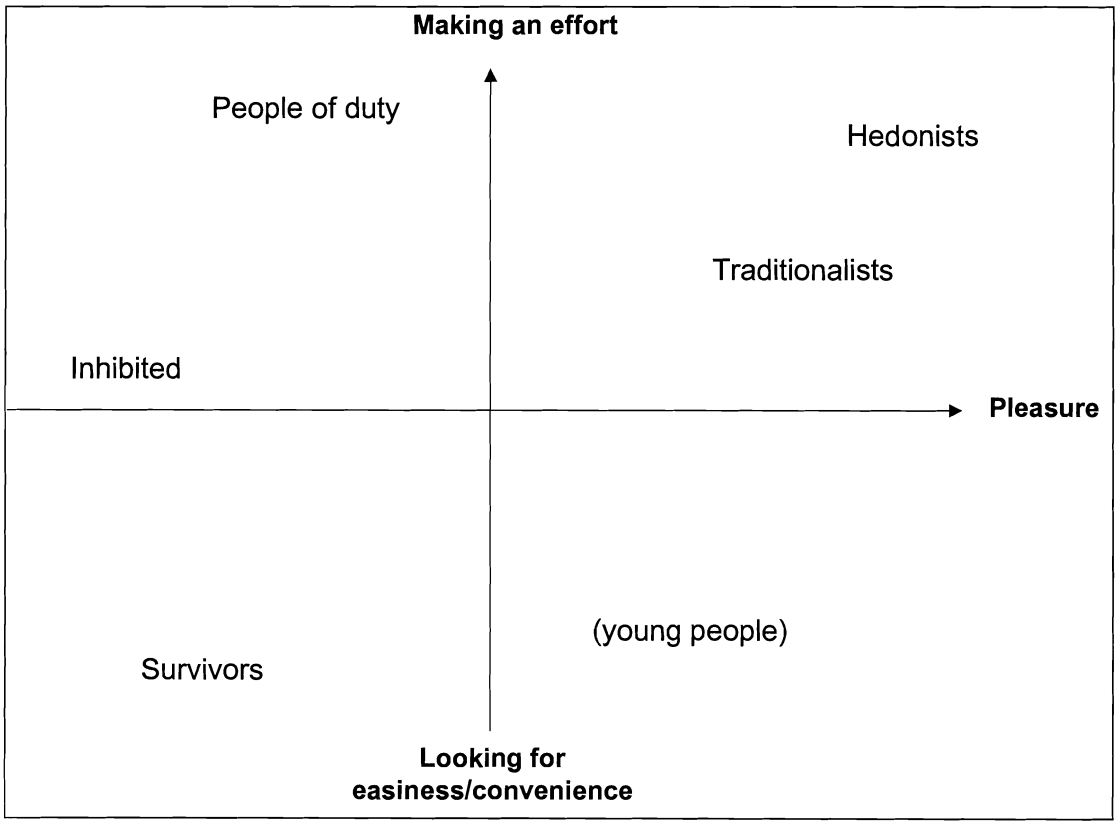

Figure 1 represents the position of these attitudes, from a purely qualitative aspect (with no measurements being made) named in order to reflect as closely as possible the characteristics of the group of people represented.

The five categories defined were traditionalists, hedonists, survivors, inhibited and people of duty.

The majority were reported to belong to the traditionalists who enjoyed eating, but were in favour of traditional food. For these people, convenience foods or foreign foods were not enjoyed and good home cooking was seen as healthy and nutritious. They enjoyed cooking although shopping was done more out of habit. Traditionalists were found in greatest proportion among the oldest respondents, especially among the ones living in couples.

The hedonists were those who gained a lot of pleasure from food and were interested in what they ate. Food was a very important part of their life, from a preparation, cooking and eating point of view. They enjoyed experimenting with food and were open to try new foods, although were not in favour of ready meals. Shopping was also a pleasure for either the outing itself or for the excitement of finding new products. A key driver for them was the quality, in the sense of specialised products. The hedonists tended to be in the younger groups still living in couples. However, there were also some older singles that still dedicated time and energy to food.

The survivors were characterised by the lack of interest in food and basically ate to live. The important thing for those in this group was to get their food in the easiest way possible. Survivors generally accepted the use of ready meals within the diet because of convenience. They showed no interest in food and did not enjoy cooking or shopping. Loneliness and tiredness were the main reasons mentioned for this lack of interest. The survivors were mainly older single elderly (over 65) whilst all of the older couples managed to find some interest as they shared meals. Older couples also supported each other in the cooking work.

The inhibited were respondents who thought mainly of food in terms of health and sickness. Foods were clearly categorised in positive and negative groups – foods to eat

and foods to avoid. Food was sometimes seen as a risk when considering diseases related to food. Generally products were discussed with reference to their use rather than taste. Some respondents seemed obsessed with fatty foods. Their whole diet was planned in order to control the intake of fat, greasy food, sugar and calories. The intake of "foreign" food and ready meals was fairly low due to the unknown associated risks. This attitude was not linked to a specific like or dislike of cooking and the amount of effort required was of little importance, the main concern was controlling what they ate. They neither seemed to like nor dislike shopping. Nearly all of the inhibited respondents were to be found in the younger couples (under 65). They were the ones anxious of staying young and healthy and of living longer.

A small number of respondents fell into the category of people of duty. They believed that meals should be prepared from scratch although they did not like cooking but felt obliged to cook proper meals for their families. Numbers in this group were low; however, they tended more frequently to be couples with children. Female respondents were clearly more inclined to people of duty than were males. This group was another group who 'ate to live'.

France

For the French elderly, food was an important part of their life; however, different attitudes were observed. Many expressed the pleasure and enjoyment of food, whereas others looked at it as merely a necessity.

For the younger groups, much enjoyment in preparation and cooking of food was expressed. For those retired, particularly those still living with a partner, more time was available for the preparation of sophisticated meals. For them it was a pleasure and often described as a hobby; when linked with visitors, it was regarded as important to please others with a delicious meal.

There were also single elderly over the age of 70 who enjoyed eating. Many of the men in this category, who were often retired businessmen, still enjoyed fine food and would spend many hours in the kitchen preparing meals. The health problems which were often

observed in this group were largely ignored by these respondents whose 'live to eat' attitude was not conducive to adapting their diet to a more healthy regime.

For some women, particularly urban women living alone, eating was reported to have a compensatory effect on their loneliness. However, preparation and cooking was not particularly enjoyed and they tended to nibble snacks and not eat proper meals. Their enjoyment of food was reported to be somewhat ambivalent.

A few women categorised as 'fitness freaks' were especially concerned with not putting on weight and so undertook fairly strenuous physical activity and controlled what they ate.

Again as noted among the elderly of other countries, those who were older and more socially isolated had lost the enjoyment of cooking and ate only to live. It was reported that many of the elderly living alone saw cooking as a necessity in order to provide themselves with food.

Spain

In Spain, meals were regarded as a means of social interaction and often an excuse for family and friends to get together. For many, both the cooking and eating remained an enjoyable experience. There was, however, a division of attitudes. The elderly in Spain were divided into several groups described according to characteristics that best described them. These groups were identified as; those worried about their health, hedonists, home economists, repressed, apathetic and traditionalists.

Those most worried about health were the ones that were the best educated on nutritional aspects and about the quality and make-up of the products they ate. They knew all the foodstuffs that for example increased sugar levels and cholesterol and controlled the amount they consumed. These were generally women in the youngest age groups.

The home economists were those people, both men and women, whose shopping habits depended completely on prices. They always chose the cheapest without taking quality into account. They checked all the advertising pamphlets that came in the junk mail and spent a large part of their free time going from shop to shop in search of the best offers. The enjoyment for this group was in the search and finding of bargains and not particularly in the pleasure of preparing and consuming the food.

The hedonists were those who enjoyed their food and lived to eat. They ate whatever they liked and were not particularly interested in any nutritional factors. Despite the knowledge that what they ate may damage their health, they were adamant that they wanted to enjoy the food they ate and not restrict their diet.

Those in the repressed group had a great appetite which, for one reason or another, they did not fulfil. For some it was health reasons that restricted them from eating what they wanted, for others it was the desire to remain slim. Others were reported to be restrained by family pressures. For this group, although they would have liked very much to 'live to eat', they were not wholly free to do so.

Contrary to the repressed, the 'apathetic' had no desire to eat and ate only as a necessity to live. Preparing and eating meals gave them no pleasure. For this reason, they consumed meals that were quick to make and tried not to spend much time in the kitchen. Generally, these were individuals who lived alone.

The 'traditionalists' were mainly those living as a couple or with families. Although women were the ones that prepared meals in this way, the men would not eat any other way. Those in this group were proud of preparing meals just as their parents and grandparents had done. They preferred to prepare the meals themselves and refused to introduce new technology into their kitchen or eat ready meals or processed food.

7.2 Summary of Attitudes towards Food

A division of attitudes towards food was seen in all European countries. Although often divided in slightly different ways, it was clear that there were certain attitudes common throughout the elderly respondents.

In all five countries there were groups of people who were found at the two extremes: hedonism (those who lived to eat) and pragmatism (those who ate to live). Those in the first category were more often than not found in the younger elderly groups who were still living as a couple. Those eating only to live were found among the oldest groups who were living alone. The attitude towards food was often more to do with being alone than actual age. Generally the 'live to eat' attitude was more prevalent in France and Spain and the 'eat to live' attitude more so in the UK, Sweden and Denmark.

Being alone for many in all countries took away much of the pleasures of eating. This was particularly true for those who had been married and had families. They were less equipped to deal with a solitary existence. Although some adapted well and continued to enjoy cooking and eating even when alone, others merely ate in order to survive. The social aspect of eating in the context of eating alone or eating in company had a profound effect for many on their attitude towards food. This was consistent in all countries and one of the main determinants of attitude.

For those who were simply bored and disinterested in food, entertaining guests often provided the motivation needed to make the planning, preparation and eating more enjoyable. In a similar way, the weekends were often highlighted as important food occasions. Many respondents often made more effort and spent more time and consequently gained more enjoyment than they did during the week. This again was mainly associated with those living with someone else. For many of those living alone, there was no difference between weekends and weekdays.

A difference between single men and single women was reported although this was not consistent between countries. In Sweden it was reported that the single elderly men were more inclined than the women to have little interest in food and saw eating as a means of

survival. In France, both single elderly men and women were reported to have a healthy appetite and enjoyment of food. It was reported, however, that in the urban areas, some of the women tended to have lost interest in food, using it to some extent to compensate for loneliness; thus, the enjoyment was, to some extent, doubtful.

For the elderly in Spain and the UK, a more detailed division of attitudes was reported. Attitudes from the other countries, however, could be seen to fit in somewhere in these divisions and this is explained below.

The hedonists described by both the UK and Spain were found in all countries and, as described, the younger elderly tended to have the greatest representation in this group. In Denmark and Sweden this group were described as those who liked to cook and eat, and to some extent those who enjoyed the social aspects of the meal (Sweden). In France this group represented the majority of elderly respondents.

Similarly the survivors or apathetic, described in the UK and Spain respectively, who had no interest in food and ate only to live, were also described in the other countries and in general tended to be the single older elderly.

Traditionalists were described as groups in both the UK and Spain. They were those who enjoyed and were proud of preparing meals in a traditional way and were not inclined towards new technologies, foreign and processed foods. In France, it was clear that many of the elderly also fit into this category, with their strong cultural tradition, which was a key driving force for many. For those respondents in Sweden and Denmark, few enjoyed ready meals and most used traditional methods of preparation and so it could be surmised that many of the elderly in these countries would also fit into this category.

A group described as 'inhibited' in the UK was mirrored by a group described as 'those being worried about health' in Spain. These groups contained those who were concerned about the nutritional content of their food and the health risks associated with certain foods rather than the pleasure of eating. It was mostly the younger elderly that fitted into this category. It was not apparent that many of the Swedish or Danish respondents fit into this group. Generally they tended to be concerned about a healthy lifestyle, which to some extent included healthier eating patterns such as lowering fat in the diet. This, however,

did not appear to have a marked effect on attitude, although it is possible that some may have been more concerned than others. In France, only a small minority of women categorised as 'fitness freaks' appeared to fit in with this group, as health concerns related to food, for the majority, were not a top priority.

It is feasible that some of the elderly respondents in all countries could fit into the group identified in Spain and described as 'repressed'. This group included those who enjoyed their food but for one reason or another could not eat what they liked. In all the countries there were those with weight concerns and to a lesser extent those with medical conditions which may have included them in this category.

A small group of respondents identified within the UK elderly respondents were described as people of duty. This described those who felt it was an obligation to cook meals from fresh ingredients, without the aid of convenience foods, although they did not get much pleasure from it. This was observed mainly with females living in couples and characterised a certain old fashioned duty to make a proper meal for the husband and family and suggests the tedium of doing this over the years. Although this attitude was not highlighted in the other countries, it may have existed among some in similar situations, particularly for women who had been cooking all their lives.

The final group identified as 'home economists' within the Spanish respondents were characterised by the fact that their choice of food and shopping outlet was completely dependent on price. The cheapest option was sought and great lengths would be taken to secure the best offers. The pleasure of eating was outweighed by the fun of finding a bargain. In a way these people lived to find a bargain rather than lived to eat. Respondents in the UK were not categorised in a similar manner. However, it was clear from the factors that influenced food choice of the UK elderly that some of the UK respondents would fit perfectly into this category. Many were avid bargain seekers and enjoyed the hunt for discounts and special offers. The quest for bargains in Sweden, Denmark and France although mentioned occasionally, was not reported as such a strong force governing the attitude of the elderly in these countries.

8. EXPLORATION OF THE SOCIAL CONTEXT

8.1 Shopping as a Social Activity

Shopping was often seen as a social activity in addition to being a necessity for the purchase of food. Thus, in social context of food, the extent to which shopping was viewed in this way was briefly explored.

In Sweden and Denmark, the social context of shopping was not explored in depth. However, the importance of shopping as a social activity was reported to increase with age in Sweden and in Denmark it was reported to be more enjoyable when couples shopped together.

In the UK, shopping was reported to be a key aspect in elderly people's lives and it was reported that the social exchanges between parents and children were often more prevalent around the shopping experience than around eating. The fear of missing out on special offers or the social aspect of shopping was also a factor that deterred some from home delivery. Many respondents feared the social consequences of not getting out to do their own shopping.

For the French, it was reported that some used shopping as a social activity, often shopping with a friend and having a cup of coffee. Markets were often linked with friendly atmosphere, and independent stores where the shopkeepers knew their clients and built up a friendly relationship with them were important aspects for the French elderly shopper. In Spain many of the elderly used shopping for food as an excuse to get out and socialise and went out every day to this end. At the other extreme, there were those who preferred to go out as little as possible, so they spaced out their shopping trips as much as possible to avoid having to meet people.

From the point of view of problems associated with shopping, for many elderly one of the problems with supermarket shopping was queuing at the check out and not having enough time to pack up bags before the next person. The supermarket was also seen as too big, too

crowded and too noisy. Constant rearranging of shelves also added confusion as to where goods were kept.

8.2 The Social Context of Eating

Denmark

For the younger elderly, dining out with friends or family was reported to occur fairly frequently, sometimes as often as once a week, but more typically once a month. For the older groups, especially those without children, they did not have the same family network, which was seen as important, and it was reported that the majority of the older groups rarely dined out.

For those who had lost their spouse, many compared their enjoyment of food to when their husbands/wives were alive and it was not such a pleasant experience as it had been then. For those eating alone, the time was often shorter because of the social aspect of chatting whilst eating. For many, eating alone was tedious and many ate whilst watching TV, listening to the radio or reading a magazine. Many preferred to eat in company rather than dine alone. It was reported, however, that some adjusted better than others did to a solitary eating experience. Most still tended to cook meals every day but many preferred eating with friends or dining out with friends or family.

Sweden

For the elderly in Sweden, eating out in restaurants was not a frequent occurrence. Price was mentioned as an obstacle to eating out. For some of the men, however, this was not the case. It was reported that for some men who lived on there own or had wives who were hospitalised, meals were eaten out in restaurants more often. Those men who were financially solvent and whose previous careers had included a lot of entertaining tended to represent the majority in this group.

The social context of eating in the home for the Swedish elderly was reported to be important in the sense that there was a significant difference between eating with someone and eating alone. For couples and those with families, the weekends were highlighted as more important from the social aspect. Often meals were more elaborate with better food and longer time preparing the food, regardless of whether the meals were shared with friends and family or just each other.

For those living alone this was not the case. Single people did not differentiate between weekdays and weekends in the same way. Many single people found food less important or not important at all. Particularly single males saw eating food as necessity only. Eating together was very important and the differences between those living alone and those living as a couple were marked.

United Kingdom

In the UK, eating out was reported to be more frequent than it had been in the younger elderly groups due to the fact that they had more time. For the single men, more so than the single women, eating out was important because of their lack of ability or motivation to cook for themselves and often occurred simply for ease and convenience. For many of the older elderly, eating out was not so reported to be a particular source of pleasure.

Regarding the social context of eating food in the home, there were major differences reported between respondents living on their own and those living with their partner. Being single was often associated with less interest in food and less energy in dealing with it. Cooking for one was considered by many not worth the effort or the money, due to the lack of enjoyment, and so less effort was made by the single person. Eating alone took some of the enjoyment out of food and it was clear that more people living in couples enjoyed their food than those living alone did.

Women tended to cope better, firstly because they were used to and able to cook and secondly because they were satisfied with eating simple meals. Male respondents tended to enjoy meat based dishes and many had switched to ready prepared meals due to a lack of skill in preparation and convenience when they had lost their spouse.

Those who had never been married, and to some extent those with no children, were better able to adapt to cooking and eating on their own as this is what they were used to. Their social life was often more organised around friends as they had never had family

There was a difference between weekend meals and those prepared in the week for some of the UK elderly respondents. The weekends tended to be more of a social occasion and the traditional Sunday roast was still upheld by a few, particularly in the younger groups of elderly and those with close families, but they were not in the majority.

Although some elderly respondents reported to have children around for meals, many did not. In the UK, the social aspect of eating with friends and family was not a deep-rooted tradition that continued into old age and few respondents invited friends for meals at home. Only women who enjoyed cooking tended to entertain and gained pleasure from the occasion. Those respondents living as a couple and the younger elderly, tending to be in the higher social classes, entertained on a more frequent basis.

Many of the elderly, particularly the older groups and the men, hardly ever had visitors. As they got older, respondents found it too hard to cook for a family, and some did not have the family nearby. For many respondents, Christmas was the only occasion when they ate together with their family.

France

For the French elderly, only those with external social activities including friends, families or club members ate out. It was also reported that many more in the younger groups than in the older group ate out. Occasions for dining out included visiting children (mainly on Sunday), and visiting friends.

Changes in circumstances such as death of spouse or illness meant that eating out became a much rarer activity (around once every 3 months). For some, especially the women, being involved with a club or other social activity and occasionally eating within this context was the only way they ate in a social environment.

For the French elderly on low incomes, dining out in restaurants was hardly ever undertaken because of the expense. Those in the higher social classes were able to dine out more often and for them it was a source of pleasure and an enjoyable social experience. Some enjoyed meeting friends, others used the restaurant as a place to eat dishes they would not normally eat at home. Those living in Paris tended to go out between once and twice a month whereas for those in Nantes eating out occurred less frequently.

Some of the widowed men (in the higher social categories) ate out at restaurants quite frequently (sometimes three or four times a week), simply for convenience.

For the French elderly there was a difference in eating habits at the weekends. For many, friends and family would be entertained at the weekends. Greater preparation went into meals with often more expensive ingredients used to prepare more sophisticated dishes. It was reported that more alcohol was consumed at the weekend. The social aspect of such gatherings was reported to be enjoyed very much by French elderly. This was, however, confined to those living as couples or with family visiting them. For those living alone, eating habits at the weekend were the same as during the week.

Spain

For many of the elderly in Spain, particularly those with partners and families at home, eating out was a rare occurrence. The main reasons why they were not frequented more often were the price and mistrust. The cost of the meal or more specifically value for money deterred people from going out to receive a meal of inferior quality to something that could be cooked at home for much less. Similarly there was a certain mistrust among some regarding the care taken in selecting the ingredients and the way the food was prepared at bars and restaurants that often dissuaded the elderly from going out. This did not, however, mean that eating was not a social event.

The Spanish culture based around family meals meant that celebrations normally took place at the grandparents' houses. For elderly people who lived with their partner, their

home was always used as a place to celebrate special events. Generally all relatives visited the grandparents' houses on non-working days or for some celebration.

It was reported that for the single elderly, although entertaining family and friends may stop, socialising for many did not. For this group, they would be invited to friends or family homes to eat. Bars and restaurants were visited more often by the single elderly, who were reported to go out regularly to enjoy themselves with friends. This was particularly so for many of the widowed men.

It was reported that there were a few who were living alone and practically did not leave the home at all. This appeared to be the exception rather than the rule for the single elderly person in Spain.

8.2 Summary of the Social Context of Shopping and Eating

Shopping was reported to be not only useful for purchasing food required, but also as a means of getting out and about and for exercise. For some in the oldest groups this was their only form of daily exercise and so was important to preserve, from both a social and physical point of view. In the UK, perhaps more so than in the other countries, shopping was more of an occasion of social exchange than actual eating of meals.

Dining out in restaurants was, in general, not a common occurrence for the European elderly. For many, the high prices and the preference for home cooking deterred them from dining out. For the younger groups and those more affluent, dining out was a more regular event. Dining out was reported to be more frequent among single men. In France, it was reported that eating out occurred more often for those living in the city than those in the more rural areas.

Sharing meals in the home with friends or family was much more common; however, the extent differed between countries. The fact of being single or living on your own was a key factor to understanding elderly people's food related behaviours. The elderly respondents agreed that sharing a meal was more enjoyable than eating alone. Food

remained much more of a pleasure and the effort made to cook was much more worthwhile when not alone. Although it was reported that some singles coped better than others, the social context remained a key factor in the enjoyment of food.

In the UK, it was reported that those who had been single all their life and to some extent those without children dealt more easily with the social aspects of food as they had not undergone such dramatic changes as children leaving home or spouse dying. Although not reported, it could be suggested that this would not necessarily be country specific and could ring true for other European elderly in this group.

The social aspects of eating, seen in Spain and France and to a lesser extent in Sweden and Denmark, meant that friends and family were often invited to share meals. This particularly occurred at weekends when food would be more lavish and the meal would be a pleasurable occasion or a celebration. This tradition was not apparent in the UK and the elderly less frequently based social gatherings around meals.

Eating out and entertaining guests decreased as people got older. In Spain, more so than the other countries, the social aspects of food tended to continue with increasing age. When the elderly were too old to entertain their families, then they would be invited to their families' houses.

9. HEALTHY LIFESTYLE

9.1 Healthy Lifestyle within Each Country

To complement the attitudes and behaviours towards food, this final section summarises the extent to which the elderly lived a healthy lifestyle and their attitudes towards healthy living.

Denmark

For the Danish elderly, particularly the younger groups, living a healthy lifestyle was seen as important for the balance of the mind and body. A healthy lifestyle was described in terms of having lots of fresh air, spending as much time as possible outside and eating a healthy diet. Having a purpose to get up for each day was also seen as extremely important for general well being and many followed a strict daily routine.

For those people no longer working, most were active and had taken up hobbies and interests in their retirement. Activities including gardening, shopping, walking, and some sports were undertaken by many in the youngest age groups. Exercise decreased with increasing age and those in the older groups were limited to some extent by their physical capabilities and lack of energy. Walking and cycling were popular in the older groups. In the oldest group, walking was their main form of exercise and almost all in the oldest groups walked daily to the shops.

Some reported to exercise to try and slow down old age and all were aware that it was important to keep moving. Loss of mobility was reported to be the biggest concern related to ageing for the elderly in Denmark.

Sweden

In Sweden, it was reported that most of the elderly taking part in the study were fairly active and healthy, particularly in the younger age groups. The younger groups in particular seemed to be very physically active, enjoying many activities. The women enjoyed activities including walking, golf, swimming and going to the gym. It was reported that the men took part in more diverse activities including tennis, table tennis, jogging and cycling. For many of the participants, gardening was also a popular active pastime. It was noted that activities decreased with increase in age and this was seen in particular with the older women. Walking was the main activity for the older respondents.

Leading a good active life physically and socially was seen as the key to remaining fit. For many food and eating contributed to this by adding quality of life and enjoyment.

United Kingdom

In the UK, virtually all the elderly respondents were aware of the benefits of physical activity on their general health and well being. It was observed that people who exercised were more interested in, and had a better knowledge of healthy food. Those in the younger elderly groups tended to be the ones in this category.

In the older groups, many people reported problems such as arthritis and weak knees which prevented them from undertaking much strenuous physical activity. However, activities such as walking, dancing, light gardening and cleaning, considered to contribute to physical well being, were undertaken by some of the older elderly.

France

For the French elderly, the concept of a healthy lifestyle was associated above all with keeping in shape both mentally and physically. Activities such as walking, jogging, bike riding, swimming, playing tennis or golf were reported to perpetuate vitality. Physical activities were undertaken by all in the youngest groups. The groups were divided fairly evenly between those who were energetic and those who were not.

Getting out and about and remaining socially active was also seen as important. For many, planning things to do each day and planning ahead for the future was also viewed upon as a positive aspect of maintaining good health. Diet and health were linked mainly to reduction in weight to enable greater mobility and reduced blood pressure. A healthy diet did not otherwise feature in the French elderly plan for a healthy lifestyle.

Spain

Although it was reported that there was a general concern about not putting on weight, the elderly in Spain were not reported to spend much time indulging in physical activity. It was reported that only one man went swimming regularly. The main exercise others took was walking and, for the women, the household chores, the shopping and cooking. For the men, exercise was reported to be limited to going to the pensioners' club and doing the routine shopping. For the Spanish elderly it appeared that a healthy diet was a more important aspect of a healthy lifestyle than exercise.

9.2 Summary of Healthy Lifestyle

For the elderly groups in France, Denmark and Sweden it appeared that a healthy lifestyle encompassed physical, mental and social well being. For Spain and the UK, less information was reported regarding healthy lifestyle.

In France, Denmark and Sweden, keeping physically and socially active was seen as very important to live a healthy life. Having a purpose for the day and a routine was also seen as important and many engaged themselves in a variety of physical and social activities.

The elderly in Spain were not reported to undertake much physical activity of any kind. However, the method of reporting and the lack of definition of the terms physical activity and exercise may have evoked this response. It was reported that walking and shopping were undertaken by all the elderly in Spain. These are physical activities which in turn

contribute to the physical and mental well being of the individual but were not emphasised as such in the Spanish report.

Similarly, in the UK the concept of healthy lifestyle in terms of physical, mental and social well being was not examined. It was, however, reported that physical activity was associated with good health and that those who undertook physical activity often had a better awareness of a healthy diet.

For all groups, physical activity was reported to decrease with age. Some reported that physical ailments inhibited activities to a certain extent, but generally little emphasis was placed on such inhibitory factors.

10. CONCLUSIONS AND RECOMMENDATIONS

10.1 Overview

This cross-cultural report brings together information from a sample of elderly respondents across the five European countries of Spain, UK, France, Denmark and Sweden. An indication of attitudes and behaviour within and between countries can be surmised from these reports; however, due to the qualitative nature of the individual studies, conclusions across the whole populations cannot be drawn.

The European elderly were seen to eat a variety of foods, which were generally consumed at three meal times, breakfast lunch and dinner. The time the main meal of the day was taken varied within and between countries. Snacking between meals was not reported to be a frequent occurrence for most of the elderly and, with the exception of some French men, neither was the drinking of alcohol.

Several factors influenced food choice for the European elderly which had important implications both for the elderly in general and for specific groups within and between countries. The strong attitudes towards food and eating often influenced food choice over and above practical or physiological problems. The life stage changes that are associated with ageing were also seen to influence dietary change.

Food choice for many of the elderly was strongly driven by habit and tradition. It was noticeable that tradition had a strong influence, particularly in France and Spain, to some extent in Denmark and Sweden and to a much smaller degree in the UK. This powerful adherence to traditional ways was a strong determinant of attitudes towards food and a healthy diet, particularly for the French elderly. The passion for food in France was deeply rooted and traditional ways of cooking and eating were not open to change. For the French and to some extent the Spanish elderly this was a major barrier to eating more healthily.

The quality of food was reported to be more important than the price for many. The quality of the food was often synonymous with fresh ingredients and cooking meals from first principles. This influenced the purchase of convenience foods and ready meals. The European elderly respondents generally did not consume convenience foods, with the exception of those in the UK, often for this reason. For some of those very elderly and for some men living alone, the use of processed foods and ready meals (particularly in the UK) was reported to be higher. Thus, the provision of ready meals and convenience foods marketed towards this group may be appropriate for the UK elderly, but not in other European countries. The strong links with habit and tradition and the insistence on quality would deter many of the European elderly from purchasing convenience foods or ready meals.

Mobility was extremely important to the elderly and it meant the freedom to choose where to shop, particularly for those in the UK, Denmark and Sweden. Limitations tended to increase with age. Those without their own transport were limited to the amount they could carry on foot or by public transport. The inconvenient location of large stores appeared to be a problem mainly for those in the UK, Denmark and Sweden. Many regretted the loss of smaller shops, which provided a more personal service. The lack of availability of home delivery, for those in Sweden and Denmark, was reported and could be an area where improvements could be made. In the UK, however, home delivery was not considered to be an option, as being able to shop for oneself was regarded as important in many respects. In the UK, the problems reported were mainly due to lack of, or the expense of public transport to the supermarkets which for some negated the viability of the journey. The improvement of public transport services for the elderly to the supermarkets could give many of the elderly a better choice and so more satisfaction with shopping, which to some would be of major importance.

It was reported that pack size was not a particular problem for most of the elderly respondents. Although pack size was mentioned to be too large for some foods, most preferred to buy larger packs as they were less expensive and those who were not concerned with the cost bought smaller packs. Foods bought in larger quantities were utilised by preparing several meals at once. Only for the single older elderly was it reported that larger packages could be a problem either because smaller packages were not available or they were more expensive.

Packaging was rarely mentioned as a problem. The difficulties of opening packages such as milk cartons, which are often a challenge to the most dextrous, were not apparent among the elderly. Although it may well have been the case that no problems were encountered, there may have been an unwillingness to acknowledge this at it may have been seen as an admission of old age.

The nutritional aspects of food to some extent influenced some of the elderly with the exception of the majority in France. However, for many, there appeared to be some confusion between healthy foods and healthy diets. The links between health and diet were often associated with the amount of fat in foods and to a lesser extent the amount of sugar. In Denmark and the UK, particularly, many would choose low fat alternatives. Concerns with weight were most often linked with choosing this type of product and generally there appeared to be confusion between healthy eating and 'diets' for weight loss. For many, the concept of healthy food was associated with particular products, which were less tasty and enjoyable. These low expectations of 'healthy foods' created a barrier for many, particularly those who reportedly enjoyed their food, towards healthy eating. Improving expectations of healthy eating could encourage many towards dietary change.

The lack of understanding or confusion over healthy eating was not, however, reported to be due to lack of information. For many, instead of encouraging healthy eating, too much information, which was often seen as contradictory, provoked mistrust, and for many it was ignored. Thus, it is apparent that information of a more scientific and relevant nature is needed to convey health messages to the elderly that will be firstly understood, secondly trusted and thirdly interesting and practical enough to be applied. Simplicity, clarity and relevance should be the key factors considered for conveying health messages to the elderly population.

The location in which the surveys were conducted in each country to some extent influenced food choice. This was seen to a greater extent in France, Sweden and Spain. For example, intake of fish may have been influenced by the location chosen for the study in Sweden. However, this did not mean that specific areas in the UK and Denmark did not influence food choice of those living in that area, only that such areas were not chosen for the study. For example, coastal areas of any country may affect the availability and intake of seafood, or market garden areas could affect the intake of fresh fruit and vegetables. It

may be important therefore to take location into consideration when addressing the needs of the elderly regarding the proximity of supply and availability of certain produce (particularly fresh fish, fruit and vegetables). Healthy eating advice and providing for the needs of the elderly may need to be tailored to be area specific in order to urge a healthy eating regime for all.

Dietary changes were reported by many of the European elderly and many were associated with life stage changes. Changes towards a healthier diet were seen to be more apparent in women than in men and were often inspired by the desire to lose weight. The onset of illness often brought about enforced dietary change. Reluctance to admit dietary change was reported in France. This was possibly an underlying influence for many in the other countries who reported no dietary change and this was possibly related to a reluctance to admit ageing.

In all of the countries there was little mention of dietary change due to practical or physiological difficulties. Only in the UK were problems with teeth and chewing were mentioned. Although consumption of red meat was reported to be reduced in many countries, problems with chewing were not reported to be the reason for this. It may be the case that for the majority of the elderly this was not a problem. On the other hand, this may have been a further example of the reticence to admit to ageing.

In all the countries, many of the elderly reported to eat less as they got older as they were not expending the same amount of energy and were not as active as they once were. From an energy point of view this is important so as to not encourage overweight and obesity. However, from a health aspect it is important that the quality of the food is increased in order to assure that sufficient of the essential nutrients are ingested. For those eating only small quantities and perhaps more so for those single people who had become disinterested in food, this could be a problem with regard to maintaining a healthy balanced diet. On the other hand, for those maintaining a healthy appetite, the potential for overweight and obesity could be a health-compromising problem for many.

The social context of food was very important to the European elderly and differences were seen between countries.

For many, shopping was seen as an enjoyable social event. In the UK in particular, shopping tended to be more of a social occasion than sharing meals and so was particularly important. Problems with shopping were mentioned by some and these included queuing at the checkout, not having enough time to pick up the bags before the next person, and the constant rearranging of shelves. This to some reduced the pleasure of the shopping experience and thus is an area where there could be room for improvement.

Dining out in restaurants was more common in the younger elderly but seemed to decrease as age increased. Sharing meals at home with friends and family was a fairly regular occurrence. This was, however, linked to the culture of the country and to some extent whether the elderly were single or living as a couple. In France and Spain and to a lesser extent in Denmark and Sweden, the social aspects were more important. Meals were often shared with friends and family. In the UK, this was not so apparent. For all the elderly it was clear that dining alone was much less enjoyable than dining with others. For many living alone, less effort was made to cook and there was for many less enthusiasm over eating.

Attitudes towards food were divided within countries and often consistent between countries. The attitude towards food and eating was strongly influenced by being alone or living with someone and often dependent on age. The social aspect was seen as extremely important by most and had a great impact on attitude.

In the younger groups, particularly those still living as a couple, many of the elderly had a positive attitude towards food and eating and were interested in and enjoyed their food (hedonists). For many in this group, the enjoyment of food was an important part of life. The key influences on food choice for these people were quality and taste. It may be for this group in particular that the promotion of healthy foods associated with quality and taste would be important to encourage healthy eating.

For many of the elderly, again in the younger groups, the pleasure surrounding food came more with the purchasing than the cooking and eating. Although quality was reported to be more important than price, bargain hunting was popular among many of the elderly, particularly reported in the UK and Spain. For some, this was the highlight of the whole

food experience and to a large extent determined their food choice. Encouraging promotion of healthier products may be an area that could be considered to enable manipulation of food choice for these groups.

Some respondents among the younger elderly groups of the UK and Spain were reported to be very cautious about their diet and were concerned with the nutritional content of food rather than the pleasure of eating it. In Sweden and Denmark, although many tended to be health conscious, none were categorised to such an extreme, although there may have been some more conscious than others were. For this group, it must be ensured that healthy messages are relevant and understood to dispel confusion and allow a more positive attitude towards healthy foods and eating. Health concerns surrounding food were not a priority for those in France and so none were deemed to be in this category.

It was clear that many of the respondents in all countries fell, to some extent, into the category described as traditionalists in the UK and Spain. For these elderly their main influential factors regarding food were habit and tradition. Interest in new foods and technologies was low for this group. Innovations in food technologies would have little relevance to this group. The main barrier to eating a healthy diet for those in this group was, for many, related to the sense of pride and superiority in the traditional ways of cooking and eating. This attitude suggests a reluctance to accept and integrate change and thus a difficulty in implementation. This attitude was seen strongly with the French elderly and was their main barrier to dietary change.

Some of the older elderly reported that for some reason they were unable to enjoy food to the extent they would like because of dietary restrictions due to, for example, illness or being overweight. Providing well planned diet ideas with enjoyable recipes and highlighting the importance of a healthy diet is important for this group. Rather than dwelling on the negative aspects of what they should not eat, focussing on the positive aspects would encourage attitude change and promote healthy eating which for this group particularly would be essential to their well being.

In all countries, there was of number of elderly who did not enjoy either eating or cooking. These groups tended to be those who were very elderly but more importantly, on their own, often having lost a partner and so lost interest in food. These would be considered as

a very vulnerable group whose nutritional status may be compromised by loss of enjoyment in food and consequent loss of appetite. This particular group of elderly who were often socially isolated should be regarded as an important group whose needs must be addressed. Bearing in mind that the social context of food is important to the elderly, it is possibly more appropriate to look at areas of improving the social context of eating for this group. In respect of food provisioning, those in this group may benefit from the availability of nutritious and tasty ready meals or foods that need little preparation. Some of the elderly had the attitude that it was not worth worrying about food eaten in later years. Many had the opinion that it is much more important for younger people to eat the right foods and that it really was not going to make much difference in old age.

Many of the European elderly believed a healthy lifestyle incorporated both mental, physical and social aspects and that keeping physically fit and mentally active was the key to a healthy life.

The inclusion of a healthy diet within the context of a healthy lifestyle varied within and between countries. In general, the Swedish elderly reported that healthy eating was particularly important and to some extent this included following a healthy diet. For those in France a healthy diet was not seen as priority for a healthy lifestyle.

For many, the concept of physical activity was often confused with exercise and some suggested various complaints, e.g. arthritis, which prevented them from undertaking physical activity. There was generally little emphasis placed on inhibitory factors which, could mean there were few, or as mentioned previously, a reticence to admit ageing. In terms of a general healthy lifestyle, again age was a strong influence. There was a general tendency for physical activity to decrease as age increased.

Although many of the elderly were aware that physical activity was important, in order to live a healthy lifestyle it is important that the elderly are aware of the many varied forms physical activity can take. For many it appeared that sports and physical exercise were the only things considered as physical activity. There are many ways for the elderly, even the older elderly, to enjoy physical activity, and promotion of these may encourage the elderly lead a more active and healthy life.

10.2 Summary of Perceived Barriers to a Healthy Lifestyle

The main barriers to for the European elderly of towards a healthy diet and lifestyle are summarised below.

The strong and deeply cultural attitude towards food, particularly apparent in France and Spain, was a major barrier to dietary change for many. Similarly many of the elderly were creatures of habit and set in their ways, particularly the older elderly, and so again many would be resistant to change. These attitudes influenced the use of convenience foods and ready meals, which for the majority were not accepted.

Being no longer in possession of or able to use their own transport influenced food choice and created problems for some of the elderly. The expense, availability and practicality of public transport to supermarkets (particularly in the UK) limited choice to some extent. For many, again particularly in the UK, resistance to home delivery meant heavy reliance on public transport. Conversely, the lack of home delivery services was reported to inhibit some of the elderly particularly in Denmark and Sweden.

The fact that bargain hunting was the main influence of food choice for many meant that the selection of foods for this group was limited by what was on offer.

The expense and unavailability of smaller packet size was a barrier mainly for the older single elderly to purchasing certain foods. For the majority, however, even the bargain hunters, price was reported as not the main determinant of choice. It is suggested, however, that there may a have been an under representation of elderly in the lower income brackets. For those on low incomes, it may be the case that price would be more of a limiting factor in food choice and must be considered, particularly in areas of low wealth.

The practicalities of shopping in supermarkets, for some, were problematic and reduced the pleasure of shopping. Queueing at check outs and worrying about the next customer and the constant rearranging of shelves were perceived as important to the elderly customer.

The social context of both shopping and eating was important. Being alone, in particular for the older elderly, was associated with loss of interest in food and loss of appetite. Interpretation and understanding of a healthy diet and confusion between healthy eating and weight loss regimes was a barrier to knowledge of healthy eating. Lack of relevant appropriate information and an over abundance of conflicting information appeared to contribute to this. For many, low expectations of the taste and enjoyment of healthy food was a barrier towards dietary change.

Consideration of location and availability of produce may be important when considering dietary requirements for the elderly. The proximity of supply of certain products (particularly fresh vegetables, fruit and fish) may be a barrier to healthy eating in certain areas.

The onset of illness for many was reported to evoke dietary change, often towards a healthier regime. This, however, was often regarded in a negative manner that in effect created a barrier and reluctance to these changes.

The attitude that it was more important for younger people to eat well, than for the elderly, was a barrier to dietary change.

Confusion over the concept of physical activity may cause psychological barriers which the elderly need to overcome to help them to lead an active, healthy life. A reluctance to admit ageing in the form of unwillingness to admit practical problems (e.g. with packaging) or physiological barriers (e.g. problems with teeth) to dietary change was an underlying problem in determining true attitudes and behaviour of the elderly.

10.3 The Future

The main issues surrounding attitudes and behaviour regarding food choice of the elderly of today have been investigated. The question is, 'how relevant will these be for

tomorrow's elderly'? As the next generation move into this category will attitudes and behaviour be different?

The life stage changes that are associated with ageing such as retirement, children leaving home, death of a partner and onset of illness are unlikely to be affected greatly in the future elderly generations. Although improvement in healthcare may delay onset of age related illness and increase longevity, these changes are inevitable. Thus, the dietary change and attitudes associated with these life stage changes may well continue through generations.

The barriers to dietary change associated culture and tradition are likely to be as relevant for future generations of elderly as they are today. Where food is an essential part of a countries' culture, such as France and Spain, tradition will continue to influence choice.

The barriers to healthy eating which stem from habit will remain, although may be different for future generations. The habits built up over the years in the younger generations are likely to continue into old age. Forming good habits in earlier years is therefore one of the most important factors for future elderly generations.

The increased exposure to and familiarity with minimally processed convenience foods and the use of microwave ovens may promote a change of attitude towards these products and methods of cooking in future elderly generations. Thus the marketing of nutritious, convenient food which, above all, is acceptable to the elderly may be possible in the future.

Many of the elderly believe that healthy food does not taste as good. For future marketing, increasing expectations of healthy foods by emphasising the sensory and hedonic aspects of the food, rather than how healthy it is, may encourage healthy eating. This, of course, must be coupled with ensuring that expectations are met by a quality product or the adverse effect may result.

The increased use of computers will see future generations of elderly as more comfortable and familiar with this technology than perhaps the present generations are. The use of Internet services thus may be more appropriate for tomorrow's elderly than for the elderly

of today. This may have particular connotations for those with mobility problems who may be more open to the online shopping services.

On the other hand, increased use of computers has meant a decrease in social and physical activity. The social context surrounding food has been found to be extremely important and so further isolation may in future compromise the diets of the elderly further. Physical activity is also important for the elderly to maintain health and quality of life. For many of the elderly today, walking to the shops was their main or only form of exercise. Future generations may bypass this with the use of Internet services and so further compromise health.

For many of the elderly today, information regarding healthy eating was often ignored or caused confusion as there was reported to be too many contradictory health messages. Information from Public Health Officials is suggested as being the most trustworthy source (Spain) and so should be exploited.

It is unlikely that there will be a sudden change in attitude towards the desire to stay young and the reluctance to admitting to ageing. Denial of some of the problems faced in old age will continue to make research of the elderly a challenge.

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APPENDIX 1: RECRUITMENT QUESTIONNAIRE (UK)

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INSTRUCTIONS:
Please use a blue or black pen
Please fill in the box like this ☒
or like this ☒

RECRUITMENT QUESTIONNAIRE P.51506

Respondent ID ☐☐☐

Location: Glasgow ☐ Birmingham ☐ Leeds ☐ London ☐

Good Morning/Afternoon,
I am conducting a survey on behalf of Campden & Chorleywood Food Research Association, an independent marke research company. We are carrying out a survey in this area. May I ask you some questions?

Name _____

Address _____

_____

_____

Telephone Number _____

Interviewers name _____

Date of interview __ __ / __ __ / __

INTERVIEWERS DECLARATION

I declare that the interview was carried out in accordance with the written instructions with the person named here who was previously unknown to me

Age

55-64year	☐
65-76 years	☐
77-84 years	☐
85+ years	☐

REFER TO QUOTA

Socioeco

A/B	☐
C1	☐
C2	☐
D	☐
E	☐

REFER TO QUOTA

Income

State pension only	☐
State pension plus other sources of income	☐

REFER TO QUOTA

Household composition

Living alone	☐
Living with company	☐

REFER TO QUOTA

Education

Educated to primary level	☐
Educated to secondary level	☐
Educated to higher further level	☐

REFER TO QUOTA

Gender

Male	☐
Female	☐

REFER TO QUOTA

Activity

Retired	☐
Working less than 10 hours per week	☐
Working more than 10 hours per week	☐

REFER TO QUOTA

Living in

City/town	☐
Village /rural	☐

REFER TO QUOTA

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INSTRUCTIONS:
Please use a blue or black pen
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or like this ☒

RECRUITMENT QUESTIONNAIRE P.51506

Respondent ID ☐☐☐

1. Do you or any of your family or close friends work in any of the industries shown on this card? **(SHOW CARD A)**

   Media | Market Research | Marketing | Public Relations | Journalism | Advertising | Food Industry (manufacture or sales)

   IF 'YES' THANK AND CLOSE INTERVIEW

2. Have you participated in any food related Market Research in the last 6 months? **IF 'YES' THANK AND CLOSE INTERVIEW**

3. Have you lived in the country for less than ten years? **IF 'YES' THANK AND CLOSE INTERVIEW**

4. Which of the following best reflects your dietary habits?

   I can eat anything I like ☐
   I have made an effort myself to cut down on a few things ☐
   For medical reasons there are a few foods that I can't eat ☐
   I am very limited in what I can eat these days ☐ **DO NOT RECRUIT**

5. How many main meals (lunch or dinner) each week do you and /or your companion shop for and/or prepare at home?

   More than 4 per week ☐
   3-4 per week ☐
   1-2 per week ☐
   None ☐
   } **DO NOT RECRUIT**

6. Do you and /or your companion shop:

   All or most of the time ☐
   Rarely ☐
   Never ☐
   } **DO NOT RECRUIT**

7. Do you smoke cigarettes? Yes ☐ No ☐

8. Do you undertake any of the following physical exercises on a weekly basis?

   Short walks ☐ Other (please state) ☐ _____
   Exercise classes (e.g. yoga) ☐ No physical activity ☐
   Swimming ☐

9. Do you use any of the following equipment in your home?

   Oven ☐ Microwave ☐ Fridge ☐ Freezer ☐

CHECK QUOTA & ASK IF RESPONDENT IF THEY WOULD BE INTERESTED IN ATTENDING A GROUP DISCUSSION

APPENDIX 2: DISCUSSION GUIDE (UK)

Welcome & presentation

Thank you for coming today.
I am ...

Principles

We are going to talk about your food habits, the idea is that you talk freely about what you actually do and think there are no good or bad answers. The best if to be spontaneous. Use this opportunity to share your experience with others...
I am not going to sell anything to you; we just want to know more about eating habits.
This is all confidential and I record for my use only.

Organisation

I am going to bring different subjects and we'll talk for 2 hours. Short break at.... to refresh ourselves.

Warm up

Tell us your name, where you live and in which conditions (on your own, with partner, friend, relative...)

Important points (proposal):
Health
Social norms
Food supply (place)

-feel of balance of diet
-type of food
-enjoying/eating to live

-organisation of food (meal /snack)

-sharing

1. **Eating habits (15', use subject as warm up)**

➔ What did you eat yesterday? Include all meals and mention if you had bits and pieces as well.

People write on a piece of paper and then tell everybody to start discussion

- Is it representative of a normal day? What is and what is not?

(get around a normal day and get some ideas about out of normal)
(concentrate on one meal, change type of meal for different groups)

↳ type of food eaten : list typical dishes you usually have *(to be written on a paper board)*
↳ repartition of food intake : how many times during the day ?
(stick to main meals or snacks all day ?)
↳ social context : how often is meal shared ? (eating out, guests...) What is different then? (in terms of food, atmosphere...)

➔ What is your favourite meal (that you actually prepare/have sometimes) ?

People write down and then tell everybody

- How often do you have it ?
- Other things you enjoy eating ?
- Are there new things you now have which you didn't/couldn't have before? Since when ? Why ?
- Are there things you don't enjoy eating ? Why ?
- Are there things you don't or can't have any longer ? Why ? Since when ?

Talk about ↳ eating enjoyment (eating to live...)
↳ importance given to food
↳ their changes in the time (related to events...)

- Do you restrict yourself through some kind of diet ?
  ↳ under/over weight issue

➔ What could make eating more enjoyable ?

➔ Do you go to fast food ? Explain.

-relation food/health
-barriers to healthy diet
-information

2. **Healthy eating**

(option)
➔ Can you describe a healthy meal (for your present needs)

(People write down ingredients/meals and then tell everybody)

- Is it the kind of food you have sometimes ?
- Enjoy it ? Why/why not ? What would make it more enjoyable ?
  ↳ evaluate health food vs. taste and enjoyment
- What stops you eating such meals ?
  ↳ evaluate financial, psychological reasons, preparation, knowledge...

➔ How important do you think healthy eating is to remain fit ?

- Are you happy with the way you're dealing with it ? Why ?
- In general what do you do to with regard to your own personal health ?
- What else could you do ?
  ↳ Evaluate interest for healthy/healthier life style
- Can I ask you for some advice/tips to remain fit...

(option)

➔ Do you know your specific needs according to your age ? Explain.

- Where do you know that from ?
- Is it something you care of ?
- Give examples when preparing a meal ?
- Do you look at the labels to check ? Give precise examples.
- Have you changed anything in your habits ? Precise. How often ?
- Why not more often ?

↳ barriers to healthy diet

↳ ways/solutions for a healthier diet

➔ Do you feel well informed about what is healthy for you?

↳ evaluate ways of improving information (content and form)

(option)

➔ Do you use dietary supplements ? food fortified with..., with added something...

- Which ?
- Why ?
- What would be a good form to take supplement ?

-way to cook, from scratch/can
-barriers to cook well (?)

3. Food preparation

Let's talk about your usual way of preparing food.

➔ What type of food do you normally cook ?

➔ What is your favourite way of cooking ?

↳ reheat, fry, MW, frozen, ready meals...

↳ most used appliances

↳ evaluate changes and explain

➔ How long does it usually take you to cook ?

➔ How often do you cook ?

➔ How do you get organised with cooking ? (planing)

- When do you decide what you're going to eat ?
- How detailed ?
- On which basis ?
- For one meal or several ?

➔ Do you enjoy cooking ?

- What do you like/dislike about it ? Why ?
- Give examples of what you like/dislike cooking ? Why?

↳ evaluate changes and explain

↳ barriers to cook : explore social issues (alone...), ability/mobility in the kitchen, health, utensils, purchase, cost, packaging, cleaning...

➔ What could make cooking more enjoyable ?

-relation to shopping
-problem for healthy diet

4. Food storing (short)

➔ What kind of food do you always have at home ? Where ? (fridge, freezer, cupboard...)

➔ What problems do you have regarding storing ?

↳ explore size, packaging, carrying, dates...

➔ Do you have to throw away food sometimes ? Why ?
- What do you do to avoid throwing food away ?

-transport/access -home shopping and delivery -what can chain do to make life easier? -barriers and solutions (portion size, packaging, finances, health/mobility)

5. Food shopping (15-20')

➔ Tell me about the way you organise your shopping
- Type of shop : multiple, independent (corner shop)…
  ↳ relate to type of food
- Where : town center or out of town ? How far from your home ? How do you go ?
- How often ?
  ↳ relate to type of food, portion, quantities
- Problems/difficulties encountered : transport/access/mobility, carrying purchase, finding things, price, portion size, labelling…
  ↳ Justify all answers
  ↳ How to improve ?
- Do you know in advance what you're going to buy ? make a list ? Explain.
- Do you have a budget ? How do you deal with money ?

➔ What type of food do you buy ?
- Fresh, frozen, processed : repartition
- Give details about vegetable, meat/frish
- What do you particularly look at when buying food ?
  ↳ Look at price, sensory, quality, quantity, brand, packaging, portion/pack size, labelling, habit…
  (is sensory a quality ?)

➔ What do you like/dislike about food shopping ? Explain.
- What would make it more enjoyable ? (think of what chains could do to improve their service)
- Test the idea of home delivery/shopping from home

Do you have anything to add ?

Thanks a lot.