Changing policies, changing patterns of care: Danish and Swedish home care at the crossroads

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Abstract Despite pursuing the policy of ageing in place, the two Nordic countries of Denmark and Sweden have taken diverse roads in regard to the provision of formal, public tax-financed home care for older people. Whilst Sweden has cut down home care and targeted services for the most needy, Denmark has continued the generous provision of home care. This article focuses on the implication of such diverse policies for the provision and combination of formal and informal care resources for older people. Using data from Level of Living surveys (based on interviews with a total of 1,158 individuals aged 67–87 in need of practical help), the article investigates the consequences of the two policy approaches for older people of different needs and socio-economic backgrounds and evaluates how the development corresponds with ideals of universalism in the Nordic welfare model. Our findings show that in both countries tax-funded home care is used across social groups but targeting of resources at the most needy in Sweden creates other inequalities: Older people with shorter education are left with no one to resort to but the family, whilst those with higher education purchase help from market providers. Not only does this leave some older people more at risk, it also questions the degree of de-familialisation which is otherwise often proclaimed to be a main characteristic of the Nordic welfare model.

Keywords Home care · Sweden · Denmark · Informalisation · Marketisation · De-familialisation

Introduction—the (not so) encompassing and generous Nordic social care model?

This article investigates the shifting boundaries between the provision of public, family and market care for older people living at home in two Nordic countries, Denmark and Sweden. In the welfare literature, the Nordic countries are well-known for their de-familialising and universal approach to welfare whereby services are paid by all and are available for all on the basis of individual needs and with the same standards (Esping-Andersen and Korpi 1987; Kautto et al. 1999). Characteristic for this type of welfare regime is the emphasis on social rights founded on social citizenship and social equality with egalitarianism as a goal. This not only accounts for the various fiscal transfers but also for the extensive social services: the Scandinavian welfare state is not only a comprehensive ‘social insurance state’ but to a high degree a ‘social service state’ (Anttonen 1998), and the provision of social care services has been described as being the key to the social welfare system in the Nordic countries (Sipilä 1997). Central aspects of universalism in care services include that services are generously offered according to need and not purchasing power, and that the same services are affordable for the poor as well as attractive for the better off (Szebehely 2005), although this common denominator of universalism is contested in the literature (see e.g. Anttonen et al. 2003; Rauch 2007).

Furthermore, the Nordic countries are assumed to operate an Adult Worker Model, emphasising the responsibilities of both women and men to engage in paid work.

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This is supported by the extensive range of care entitlements in respect of children and older people (Lewis 2002), which essentially ensures that relatives should not stand alone with extensive care duties. Hernes (1987) described this process of the Scandinavian welfare states as the family ‘going public’, as the ‘caring state’ took a larger share of the care responsibilities for children. This off-loading of care from the household, or what Lister (1995) has termed de-familialisation, thus concerns independence within familial care relationships from the perspective of the care-receiver, in not being dependent on receiving care from the family. From the perspective of the care giver it also means not being obliged to provide care (Leitner and Lessenich 2007). Accordingly, the Nordic welfare model is also highlighted for the way it enhances women’s options in relation to care and work. Early on, this made Hernes (1987) characterize the Nordic countries for their ‘women-friendliness’ enabling women to survive as independent workers and decreasing women’s economic dependency of the family.

Although Hernes was originally referring to the role of the extensive child care policies in the Nordic countries, parallels can be drawn to the role of the—in relative terms—generous care services for older people, which also enable older people to be independent of the family and liberate (female) family members from the obligation to care. Characteristic for the Nordic countries is that extensive care services are available for older people needing care, mainly in the home, as ageing in place is the prevalent policy. Also, care provision takes place within a highly regulated and formal setting with mainly professionalised and qualified staff members (Anttonen and Sipilä 1996; Rostgaard 2004).

Public preference and support for the formal care system is also high: in a recent Eurobarometer survey, Danes and Swedes are least likely to point at family care as the ideal form of care for an older and frail parent: 80% of Swedes and 72% of Danes would prefer formal care, compared to an EU27 average of 37% (Eurobarometer 2007, p. 67). Daatland and Lowenstein (2005, p. 178) found similar preferences for services over family care amongst older people in Norway, in contrast to southern Europe. The authors interpret the findings as a reflection of the comparatively generous service levels in the north, and thus of ‘opportunity’ rather than of ‘culture’.

However, extensive public provision has never meant the depletion of informal caring in the Nordic countries, although, as Kröger (2005, p. 243) notes, “the Nordic countries have sometimes been accused of having been so charmed by their abundant public care services that they have ignored the significance of informal care”. Even in the Nordic countries where the family does not have a legal responsibility to provide care, family care continues to be

an important source of care of older people, and, at least in the case of Sweden, of increasing importance in recent years (Sundström et al. 2002; Johansson et al. 2003; Szebehely 2005). For instance, Sundström et al. (2002) have estimated that, in Sweden in the year 2000, families provided 70% of all community care for elders 75+; an increase from 60% in 1994. Such trends of informalisation of care have not been shown in Denmark. In Denmark, 5.7% of the working population report to help an older relative at least once a week whilst this is the case for 9.3% in Sweden (EU27 = 12.7%; Eurofound 2005).

That the increase of informal care of older people in Sweden is somewhat against Nordic welfare ideals is evident in the same Eurobarometer survey where 70% of respondents in Sweden agree that ‘Dependent people have to rely too much on their relatives’, which is in line with the EU27 average of 71%. In comparison, only 41% of Danish respondents (and the lowest country average in the study) agree with this statement. And more Swedes expect to give up work or reduce work hours to take care of their older parents: 10% of respondents in Sweden, compared to 5% in Denmark; EU27 = 8% (Eurobarometer 2007).

The policy approach of elder care in Sweden and Denmark

What may explain this difference in trust in the adequacy of the formal care system and in involvement in informal care? Overall, when it comes to the investment in elder care, both Sweden and Denmark are amongst the most generous spenders in Europe, measured as public spending on elder care as proportion of GDP (Huber et al. 2009, see Table 1). Sweden spends somewhat more than Denmark, to a large extent but not fully explained by the higher proportion of 80 years and older in the population (Table 1).

Despite higher public spending in Sweden, the Danish elder care services reach a larger proportion of the elderly population: twice as many older people (65+) in Denmark than in Sweden receive home care (18% compared to 9%).¹ There is a slightly higher take-up of residential care amongst the 65+ in Sweden than in Denmark, but taking the home based and residential services together, 23% of Danish older people (65+) are covered, compared to 16% in Sweden.

The hours of care provided to the home care recipients are also quite different in the two countries (Table 1). It is much more common to receive small amounts of help in Denmark where 11% of the older population receive 2 h of home care per week or less compared to 3.6% in Sweden.

¹ Among the oldest, 80+, the difference in home care is equally stark: in Denmark 43% of the 80+ receive home care, compared to 22% in Sweden (Nososco 2009).

Table 1 Expenditure, demography and tax-funded care services for older people, Denmark and Sweden (2007–2009)

	Denmark	Sweden
A. Services for older people, public spending (% of GDP, 2007)	1.7	2.4
B. Older people in population (% , 2008)		
65 years+	15.7	17.9
80 years+	4.1	5.4
C. Services for older people, coverage (% of population 65 years+, 2008 (Sweden) and 2009 (Denmark))		
Eldercare services, total	22.5	15.6
Residential care including sheltered housing	4.9	6.4
Home care in ordinary homes	17.6	9.2
Of which		
Low intensity: 2 h of help per week or less ^a	11.0	3.6
Medium intensity: 2–19.9 h per week ^b	6.1	4.7
High intensity: 20 h of help per week or more ^c	0.5	0.9

Sources: A Huber et al. (2009, p. 99); B Nososco (2009); C Nososco (2009); Statistics Denmark (2010); NBHW (2009)

^a In Sweden, 9 h per month or less

^b In Sweden, 10–79 h per month

^c In Sweden, 80 h per month or more

At the other end of the home care spectrum, we find in both countries a very small group of older people who receive large amounts of help (20 h or more per week). However, as shown in Table 1, such extensive home care is more common in Sweden (0.9% compared to 0.5% in Denmark), illustrating the more strict targeting of home care services in Sweden at those with larger care needs. On average, a Danish home care recipient receives 3.7 h of help per week compared to 7 h per week in Sweden (Statistics Denmark 2011; NBHW 2009).

Overall, the much higher coverage of home care in Denmark is thus mainly caused by considerably more elderly Danes receiving small amounts of help, especially with cleaning. In both countries, the large group with small amounts of help uses less of the total amount of home care hours than the small group in need of a lot of help, but certainly more so in Sweden than in Denmark. The difference in the service level reflects some noticeable differences in the policies of home care for older people in the two countries in the way that the formal policy of home care for older people accentuates the importance of the informal network resources.

First, however, some similarities are worth pointing out: in both countries, home care has continued to be a public responsibility, organised, financed and in most cases also provided by local authorities, although, in both countries it is possible to receive publically financed home care delivered by a private for-profit provider. Since, the 1990s,

the rate of private-for-profit companies offering services paid out of pocket operating parallel to the public home care system has been increasing, and help, mainly with cleaning, bought from the market is becoming more common. In both countries, older people have been encouraged to purchase market-based produced home care services with tax deduction schemes. A Swedish scheme, introduced in 2007 and covering all age groups, makes it possible to deduct 50% of the expenditure on household services or personal care purchased on the market up to 11,000 € annually. In 2009, the tax deduction was used by 3.5% of 65 years+; twice as many as in the previous year, and significantly more often amongst high income older persons than amongst those with lower incomes (Statistics Sweden 2011). In Denmark, there is no recent information on take-up, but the scheme entitles older persons 65+ to a 30% subsidy for the purchase of assistance with domestic chores only, with a max. subsidy ceiling of 3,200 € yearly per household.²

The main difference between the countries is reflected in the changes in the publicly funded home care provision during the 1990s: in Sweden, the provision of home care expanded until the early 1980s, covering 16% of the 65+ in 1980 (Szebehely 2005). Since then, coverage has declined to the present 9% (Table 1). In Denmark, the coverage rate has not changed since 1982 when 18% of 65+ received this service (Rostgaard and Fridberg 1998), and Denmark is the only country in Scandinavia to provide home care free of charge. In Sweden, since a max-fee reform in 2002, the maximum fee is around 180 € per month, and persons with low incomes are exempt from paying fees. The fees are income-graded, and for people only needing a few hours of help with domestic chores, such as cleaning, shopping or laundry, it is often cheaper to buy private for-profit services, especially since the introduction of the tax deduction in 2007. Hence, the tax deduction is an incentive for older people with medium to high pensions to purchase services at the private market, rather than to turn to the publicly funded home care services (Meagher and Szebehely 2010).

To conclude this section, there is an important dividing line between the countries. During the 1990s and 2000s, Denmark has maintained the high social investments in the (free) public care system, whilst Sweden to an increasingly degree has targeted home care at those who are most frail. Home care services for older people in Denmark have thus, unlike the development in many other countries, developed into a relatively generous public service where home care

² From September 1, 2011, a new fiscal scheme, *Boligjobordning* replaces the old scheme. The new scheme will be in place until the end of 2013 and allows every individual to deduct 2,000 € annually for the cost of amongst other cleaning services.

resources are spread to both those with extensive personal care needs and those only in need of help with domestic chores. In Sweden, coverage of public home care has declined steadily since the early 1980s, now mainly targeting those with the greatest personal care needs. The question is whether this has created a variation in care provided by family and market for elders across the two countries.

Research questions

Using comparable Level of Living surveys from the two countries, we analyze the nature of the provisions and combinations of care from the public sector, the family and the market for older people as of mid 2000s. More specifically, we ask how the variation in the public home care policies—in Denmark spreading the home care and in Sweden targeting the most needy—affects older people with varying needs in the two countries: are the implications of targeting that older people with small needs in Sweden have to rely on other sources of care, such as the family and the market? Are the implications of spreading the home care more thinly that older people in Denmark with smaller needs can rely entirely on home care services whilst those with larger needs—more than in Sweden—have to combine formal care services with care from family or market? We also look into whether differences in social backgrounds affect the combination of care resources in the two countries, using education as a proxy for social class. Finally, in the conclusion, we address how the findings correspond with the Nordic model of generous, universal and de-familialising services.

Findings—public, family and market care in Sweden and Denmark

In this section, the relationship between informal and formal care in the two countries will be investigated through an analysis of two national data sets, focusing on the use of public, family and market care amongst older people with different care needs.

Data

Danish data stems from a longitudinal database of older people (*Ældredatabasen*), a survey that is fielded and collected by SFI-SURVEY. The database consists of three waves of survey data from 1997, 2002 and 2007, of which we use the latest data. In 2007, a national representative sample of individuals born every fifth year from 1920 to 1945 consisting of 9,633 individuals aged 52–87 years was interviewed (response rate 74%). The Swedish data is from

the Swedish Surveys of Living Conditions (ULF), carried out yearly since 1975 by Statistics Sweden. In the wave from 2004 to 2005 used in this study, a national representative sample of 10,177 individuals 16–103 years old was interviewed (response rate 75%).

The analysis is limited to 67–87 year olds living in their own homes (not in residential or nursing homes), altogether 4,096 in Denmark and 1,686 in Sweden. This sample is used when we analyze differences in needs in the two countries. In the analyses where provision of care is analyzed, the basis for the analysis are respondents who report need for care, as only these persons are asked about sources of care: 827 individuals in the Danish and 331 in the Swedish sample.

Need for care and background characteristics of the sample

As is evident from Table 2, fairly similar proportions in the two countries report that they need help with different daily activities. Eight out of ten respondents report that they have no need for help with cleaning, grocery shopping, laundry, cooking or bathing (78% in Denmark and 80% in Sweden). There are some differences between the countries: a larger proportion in Denmark than in Sweden report that they need help with one task only (11.5% compared to 6.2%), in most cases help with cleaning. The main conclusion from Table 2 is, however, that the considerably higher coverage of home care in Denmark (reported in Table 1) does not seem to reflect significantly higher care needs in Denmark.

In the following, we will discuss care patterns amongst older people who need help with at least one of the tasks reported in Table 2. The composition by age, gender,

Table 2 Need for help for certain items amongst 67–87 year olds living in their own homes

	Denmark (4,096)	Sweden (1,686)
Need help with		
Cleaning	17.1	15.7
Grocery shopping	8.3	13.6
Laundry	7.0	10.8
Cooking	6.7	6.6
Bathing	3.4	4.8
Need help with 0–5 of the above mentioned tasks (%)		
0	78.3	80.3
1	11.5	6.2
2	4.8	4.3
3	2.5	3.1
4	1.7	3.2
5	1.2	3.0

Denmark (2007), Sweden (2004–2005). Percentage (*n* within brackets)

Table 3 Background variables

	Denmark (816–827)	Sweden (328–331)
Age		
67–76	36.6	37.6
77–87	63.4	62.4
Gender		
Men	38.6	33.0
Woman	61.4	67.0
Household type		
Single living	50.8	50.1
Cohabiting	49.2	49.9
Education		
≤9 years	77.0	61.8
10 years+	23.0	38.2

67–87 year olds living in their own homes, needing help with one or more practical tasks. Denmark (2007), Sweden (2004–2005). Percentage (*n* within brackets)

Table 4 Sources of help by need

		Tax-funded home care ^a	Help by family/friends	Help by private market provider ^b
Need help with 1–2 tasks	Denmark (617–618)	49.4	16.2	14.2
	Sweden (176)	24.1	42.0	12.6
Need help with 3–5 tasks	Denmark (202–205)	68.8	45.9	18.8
	Sweden (154–155)	49.7	53.2	7.0

67–87 year olds living in their own home with smaller and larger care needs. Denmark (2007), Sweden (2004–2005). Percentage (*n* within brackets)

More than one source of help could be mentioned

Figures marked in bold indicate a statistically significant difference between the two countries ($p < 0.05$)

^a Publically and privately provided, publicly funded home help and care

^b Privately provided help and care, paid out-of-pocket

household type and education of these groups is reported in Table 3. As shown in the table, there are only minor differences in age and household type in the two countries, but the Danish sample consists of somewhat more men than the Swedish sample, whilst the education level is higher in the Swedish sample.

Sources of help

In the two surveys, respondents were asked about sources of help received within and outside the household. In the Danish and Swedish context, help *within* the household is almost entirely spousal care, not care by children or other

family members since very few older people live with their off-spring in these countries, compared to other EU countries (Ogg and Renaut 2006). Almost all co-habiting older people in the samples report receiving help from a spouse (or occasionally another household member), and this does not differ between the two countries. Instead we will focus on sources of help *outside* the household: *tax-funded home care services, family or friends* (in Denmark ‘children and others’ and in Sweden ‘family members outside the household or friends’) and *privately purchased help*. These three sources of care are reported in Table 4.

As shown in Table 4, a significantly larger proportion in Denmark than in Sweden report receiving *tax-funded home care*; in Denmark 49% of older people with smaller care needs receive home care services, compared to 24% of the Swedish sample. Also amongst older people with larger care needs do home care services in Denmark reach a larger proportion than in Sweden (69% compared to 50%). Thus, in both needs groups more older people are covered by home care services in Denmark—not only those with smaller care needs, which was to be expected on account of the difference in policies and on the basis of the statistical data described above.

An even more striking difference between the two countries is that considerably more Swedish than Danish older people with smaller care needs receive *family care*, i.e. help from their children, other family members or friends (42% in Sweden compared to 16% in Denmark). In both countries, with increasing care needs family care is more often used, and the country difference is much smaller and not significant (53% in Sweden and 46% in Denmark).

Finally, *help purchased at the market* plays a less important role than family care and tax-funded home care services in both countries, but especially so in Sweden. Yet we do see that the country difference in market provided help increases in line with the number of needs, i.e. older people with higher needs are far more likely to make use of market provided care in Denmark than in Sweden.

Another way of reading the results in Table 4 is that in Sweden, for both groups of older people, the most frequently reported source of help is the family. In Denmark, the most common source of help is the tax-funded home care services.

However, from Table 4 we do not know to what extent the respondents combine different sources of care. This is shown in Fig. 1.

Looking at the combination of home care services and family care first, Fig. 1 shows that amongst older people with *smaller care needs*, the largest group of the Danish sample (40%) receives home care services only, whilst the largest group of the Swedish sample (35%) receives family care only. Similar proportions (7–9%) in the two countries receive care by both family and home care services.

Fig. 1 Combinations of care by needs. 67–87 year olds living in their own homes with smaller and larger care needs. Denmark (2007), Sweden (2004–2005). See notes in Table 4 for definition of sources of care

Amongst older people with *larger care needs*, in both countries it is more common to receive a combination of public care services and family care (39% in Denmark and 33% in Sweden), but also in this group considerably more Danish than Swedish older people receive home care services only (30% compared to 17%), whilst more Swedes than Danes receive help by family only (20% compared to 7%). These figures suggest that in particular amongst older people with smaller care needs, but to some extent also amongst those with larger care needs, family care in Sweden is used in situations where Danish older people receive home care services.

Figure 1 also shows the reliance on the market provided care. To rely entirely on privately purchased market care is quite rare in both countries (7–8% amongst those with smaller care needs and 3–5% amongst those with larger needs). This suggests that, especially in Denmark and in particular amongst those with larger care needs, services purchased from the market are often used in combination with home care.³

In order to test our assumptions about universality across social groups of the home care, we include information on educational level. Table 5 reports the use of the three forms of care amongst older people according to levels of education.⁴ We note that the country difference is similar in both educational groups: significantly more older people use home care services as well as privately

Table 5 Sources of help by education

	Tax-funded home care	Help by family/friends	Help by private market provider
Education			
≤9 years			
Denmark (624–626)	54.3	25.4	11.5
Sweden (200–201)	36.8	54.4	6.4
10 years+			
Denmark (185–186)	54.3	16.7	27.6
Sweden (127)	36.5	34.1	15.1

67–87 year olds living in their own homes, needing help with one or more practical tasks. Denmark (2007), Sweden (2004–2005). Percentage (*n* within brackets)

Figures marked in bold indicate a statistically significant difference between the countries ($p < 0.05$). See also notes in Table 4 for definition of sources of care

purchased market services in Denmark than in Sweden, whilst significantly more older people in Sweden than in Denmark receive family care. But whilst the home care services seem to be used to the same extent by those with longer and shorter education in both countries, *family care* is more often used by older people with *shorter education* (compared to those with longer), whereas older people with *longer education* are much more inclined to purchase *private help at the market* (compared to those with shorter education). This indicates that with increasing educational level (and presumably financial means) older persons are more likely to turn to the market instead of the family.

In order to further investigate the relationship between social group, need and sources of care, a multi-variate analysis has been carried out (Table 6), using separate logistic regression analyses for each country. The analysis shows the probability of receiving each of the three forms of care by older people with larger care needs compared to

³ In both countries very few older people with care needs go entirely unaided. The majority of those who do not report help from sources outside the household are helped by a spouse. In the Swedish sample only 1% report that they do not receive any help despite a need.

⁴ We use level of education as a proxy for social class since the questions about occupation were asked in a different ways in the two surveys and thus do not allow us to compare socio-economic groups. However, an analysis of the Swedish data (not reported here) shows that the class-related pattern of help is very similar whether we compare those with lower and higher education level or manual workers and salaried employees.

Table 6 Sources of help by needs and education: logistic regression, 67–87 years old, living in their own homes, needing help with one or more practical tasks

	Tax-funded home care OR (<i>p</i> value)		Help by family/friends OR (<i>p</i> value)		Help by private market provider OR (<i>p</i> value)	
	Denmark	Sweden	Denmark	Sweden	Denmark	Sweden
Number of needs						
1–2	1 (0.000)	1 (0.000)	1 (0.000)	1 (0.003)	1 (0.106)	1 (0.245)
3–5	2.368	5.000	4.654	2.153	1.438	0.662
Education						
≤9 years	1 (0.668)	1 (0.388)	1 (0.014)	1 (0.001)	1 (0.000)	1 (0.006)
10 years+	0.915	1.265	0.553	0.443	2.975	2.904

Odds ratios, controlling for gender, age and household type. Denmark (2007), Sweden (2004–2005) (*n* 809–812 in Denmark, 327–328 in Sweden)

Figures marked in bold indicate a statistically significant difference ($p < 0.05$). See also notes in Table 4 for definition of sources of care

those with smaller needs, and the distribution of the three care forms amongst older people with longer education compared to those with shorter, controlling for gender, age and household type. We assume that factors such as gender (men are more likely to be outlived by partner), household type (single living older persons have no partner to provide care) and age (assessment of need for publically provided care may be age-biased, and need may increase with age) may influence the sources of care available for older people.

In both Denmark and Sweden, older people have a significantly higher probability of receiving home care services if they have larger needs. Thus in both countries, *home care services* seem to be provided according to need, but not to the same extent: in Denmark, an older person with larger care needs has more than twice the probability of receiving home care services compared to a person with smaller care needs (odds ratio 2.368), controlling for differences regarding gender, age, household type and education in the two groups. In Sweden, the corresponding odds ratio is 5.0, suggesting that home care services are more strictly targeted to those with larger needs in Sweden than in Denmark, thus confirming the results of our previous analysis.

And whilst in both countries *family care* is significantly more common amongst older people with larger care needs, compared to those with smaller needs, the difference is larger in Denmark (odds ratio 4.654 compared to 2.153 in Sweden). This suggests that family care in Denmark is mainly provided to older people with larger care needs (often in combination with home care services as we have seen in Fig. 1), whilst family care in Sweden is used both instead of home care for older people with smaller needs and together with home care for older people with larger care needs.

Privately purchased help at the market seems to be used somewhat more amongst Danish older people with larger

needs, and somewhat more amongst Swedish older people with smaller needs, but in neither country there is a significant difference between the two groups of older people. The finding corresponds well with the data on provision of public home care services: Danish older people with larger needs may need to top up public services as these are thinly spread, and Swedish elderly with smaller needs may need to purchase private services as an alternative to the public services.

Looking at the two *educational groups*, the similarity between the two countries is striking. When controlling for needs, age, gender and household type, neither in Denmark nor in Sweden there is any statistically significant difference between the two educational groups in use of tax-funded *home care services*. However in both countries *family care* is significantly more common amongst older people with shorter education: a person with shorter education has about twice the probability of receiving help from a family member or a friend, compared to an older person with a longer education. Finally, in both countries *privately purchased help* is significantly more often used by older people with higher education—odds ratio 2.975 in Denmark and 2.904 in Sweden.

Discussion and outlook

Changes in policies of home care in Denmark and Sweden seem to have affected older persons in the availability of sources of care to a different degree. Overall, for older people with need for care it is today most common in Denmark to receive tax-funded home care, whilst it is most common in Sweden to receive help from the family. In both countries, services purchased from the market play a less (but perhaps increasingly) important role. More specifically, the spreading of public home care resources in Denmark means that older persons even with small needs

are likely to receive tax-funded home care—although in many cases only 30 min or so a week or every fortnight is provided—whilst older people in Sweden mainly receive public home care only when needs are more extensive. And although older people are more likely to receive help from the family with increasing needs in both countries, older Swedes seem mainly to rely on the family, whilst Danes also turn to the market. Actually in Denmark, older people with higher education more often purchase market help than receive care from a family member.

Based on the general public preference for and trust in formal elder care in both countries, we know that Nordic older people prefer to rely on the public home care system rather than the family and the market (e.g. Daatland and Lowenstein 2005; Eurobarometer 2007). Our results thus suggest that the extensive involvement of the family in Sweden, compared to Denmark, is a strategy of necessity rather than choice. An earlier Swedish study has shown that older people with lower education do not prefer family care more than do highly educated elders (Szebehely and Trydegård 2007). Yet the present study shows that older persons with shorter education in both Denmark and Sweden use family care to a higher degree, whilst it is more common for a person with longer education—and hence probably with greater financial resources—to purchase market care.

The similar pattern in the two countries when it comes to the use of family care versus market care according to the educational background suggests that in both countries a cut in publicly funded home care services would affect older people very differently, and be depending on their ability to purchase extra-familiar care. This has proved to be the case in Sweden where the cut-backs of home care services already have led to a *dualisation of care*: as a result of the decline in tax-funded home care services since the 1980s, older people with longer education have turned to the market, whilst older people with shorter education have instead increasingly compensated the loss of home care services with family care (Szebehely 2005; Szebehely and Trydegård 2007). We asked in the beginning whether the targeting of care in Sweden implied that older people with small needs would have to rely on other sources of care, such as the family and the market, and we must conclude: yes, but depending on educational background. Whilst those with higher educational background can choose whether to use market or family care—and often choose market care—those with low educational background must rely on the family.

We also asked: what are the implications of spreading the home care more thinly in Denmark? Our hypothesis was that this might enable especially those with smaller needs to rely entirely on home care services whilst those with larger needs—more than in Sweden—would need to

combine formal care services with care from family or market. Our findings suggest that also those with higher needs in Denmark are better cared for via public services than in Sweden, i.e. spreading of resources does not result in poorer public care to those with higher needs—within this country comparison. But we also find that those with higher needs in Denmark are more likely than in Sweden to top up public services with market provided care, i.e. they see a need for additional care, which suggests that public care services might not be entirely sufficient for this group. An indicator of this is that 38% of those with higher needs in Denmark in fact in the survey report that they are in need of more care. Though it is not within the scope of this article to consider the actual quality of the services provided in the two countries, another negative aspect of the more thinly spread home care in Denmark is that there seems to be more complaints regarding the amount of practical help provided than in Sweden (Egger Nielsen and Goul Andersen 2006, p. 181; NBHW 2010, p. 7).

In comparison to Sweden, the combined strategy in Denmark of spreading resources thinly to those with small needs and still covering those with higher needs thus seems more successful in covering the older population in need of help, but less satisfactory for those with larger needs. However, it should be noted that most recipients of home care in both countries are satisfied with the services and in an international comparison there is a very high trust in the quality of formal care in both Denmark and Sweden, in that four in five Swede and Dane (80 and 81%) agree that ‘Professional care staff looking after dependant elderly people are highly committed and are doing an excellent job’, compared to 59% on average in EU27 (Eurobarometer 2007, p. 74).

Comparing the degree of universalism in these two country representatives of the Nordic model, we conclude an important similarity between the two in that the formal home care services are used to the same extent by all social classes. However, recent legislative changes in Sweden, in particular the introduction of a generous tax-deduction for household services, probably work as an incentive for better-off groups of Swedish elders to leave the home care services and increasingly turn to the market instead. Furthermore, targeting of resources at the most needy, as is the policy in Sweden, tends to create inequalities in access to care, leaving older people with short education with no one to resort to but the family, unless they have extensive needs. This raises also the issue of social rights to high quality care. Family care may cater for individual needs and preferences, but just as market care is conditioned on the ability to pay, family care is conditioned not only on actual access to family but also on affection and sense of obligation, without any guarantee neither of availability nor of willingness to be provided. And whilst there is no

guarantee that neither market care nor family care is based on a professional and qualified approach to care, a poor quality market provider may be exchanged, whilst this is more difficult with care provided by a family member. From the perspective of the carer, we have outlined how the Nordic model has been characterized as being de-familialising leaving women (and men) with the *option* of whether or not to provide care, and thus facilitating the Adult worker model (Lewis 2002; Leitner and Lessenich 2007). The development of the home care system in Sweden, however, clearly questions the de-familialising potential of the Swedish version of the Nordic model of care, with consequences not only for older persons, but also for their (often female) carers.

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