The following scenario illustrates the challenges of communication, coordination, and collaboration in health and social care for a multi-illness patient being cared for at home.

Scenario 1 – Arne’s Current Situation

Arne, an 82-year-old widower, lives alone following the death of his spouse several years ago. His son, who resides in another town, maintains contact with the healthcare and social care providers involved in Arne's care.

Arne has multiple chronic conditions:

- A stroke resulting in left-sided paralysis
- Diabetes
- Angina
- Emphysema
- High blood pressure
- Leg ulcers
- Advanced prostate cancer

His stroke and emphysema significantly impair his health and independence, requiring substantial daily support. Arne receives assistance from various services, including hospital care (for periodic admissions), home healthcare, and municipal social care. He also maintains regular contact with his diabetes nurse.

Support Provided

Arne relies on municipal care for help with daily living activities:

- Showering twice a week
- Cleaning and laundry once a week
- Meal preparation three times daily

- Transportation to hospital appointments
- Assistance with toileting and getting into bed

Occasionally, he stays overnight at the hospital for observation.

In a typical week, Arne receives visits from numerous healthcare and social care providers:

- Daily visits from home care staff for routine tasks
- Evening and night visits from municipal caregivers
- Daily nursing visits for insulin administration and medication management
- Twice-weekly visits from a primary nurse for health checks and wound dressing
- Physiotherapy sessions several times a week for breathing exercises
- Home visits from his doctor as needed

On average, this amounts to approximately 10 visits per day, often involving 10–12 different individuals. Occasionally, two caregivers arrive together for certain tasks.

The Complexity of Care

Arne exemplifies the growing population of elderly patients with multiple conditions, who often require integrated care across multiple providers. According to the Swedish Association for General Medicine, the Swedish Geriatrics Association, and the Swedish Internal Medicine Association, elderly patients with multiple conditions are defined as those with complex needs requiring close collaboration between municipal, primary, and inpatient care. For statistical purposes, they are identified as individuals:

- Aged 75 or older
- With three or more diagnoses in different categories
- Hospitalized three or more times in the past year

A 2001 study estimated that roughly 7% of people aged 75 or older fit this description. Applying this proportion to Sweden's 2023 population suggests there are approximately 75,000 multi-illness elderly individuals, a number expected to exceed 100,000 by 2050 due to population aging.

This demographic trend underscores the increasing demands on health and social care systems to enhance coordination and communication to meet the needs of patients like Arne.