

# Croatia's Primary Care Reform What It Means for Your Practice

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Croatia's 2013 primary care payment reform, introducing a mixed capitation and fee-for-service model, reshaped rural family practices. The changes forced a reevaluation of patient panel sizes, preventative care strategies, and administrative efficiency.

## KEY TAKEAWAYS

- lightbulb
- The Pivot: Mixed payment models demand proactive panel management and targeted preventative care strategies to optimize revenue and patient outcomes.
- The Data: The study showed shifts in practice behavior related to achieving targets for preventative services under the new payment structure.
- The Action: Implement regular audits of patient panel demographics and preventative service delivery to identify gaps and opportunities for improvement under capitation.

Croatia's 2013 reform introduced a mixed payment system. It combined capitation - a fixed payment per enrolled patient - with fee-for-service, or payment for specific services.

The model mirrors systems in other European nations and some US value-based care efforts. These systems are common. The stated goal, consistently, was to control costs while maintaining or improving quality. Cost control was paramount.

Understanding the specific weights assigned to capitation versus fee-for-service within contracts becomes vital. Know your revenue mix. Are you heavily reliant on fee-for-service revenue? Or does capitation form the bulk of your income? This shapes your strategy.

This understanding is critical for resource allocation and strategic planning.

Effective patient panel management under capitation proved critical. Overly large panels can lead to rushed appointments and decreased quality. Small panels, conversely, may not generate sufficient revenue. It's a balance. This mirrors

recommendations from various practice management organizations. They urge careful consideration of provider capacity and patient needs when determining panel sizes.

The American Academy of Family Physicians (AAFP) also weighs in on optimal panel size for comprehensive care. They emphasize accounting for patient complexity and physician workload when setting these sizes. Practice leaders must consider this.

The Croatian reform incentivized preventative care. Specific targets tied directly to payment drove the change. This aligns with global trends pushing preventative medicine, seen in guidelines from groups like the USPSTF (United States Preventive Services Task Force). It's a growing focus.

These targets force practices to rethink resource allocation for preventative care. Are screenings proactively scheduled, or do staff wait for patient problems to arise? Dedicated staff for outreach and education matter. Is a patient portal helping? An efficient system is key.

Mixed payment models often bring increased administrative burden. Reporting requirements and complex billing procedures strain resources. Croatia is not unique here. The administrative simplification goals outlined in HIPAA (Health Insurance Portability and Accountability Act) in the US remain unmet. Paperwork persists.

Practices continue to struggle. Consider investing in technology to streamline billing and reporting. Outsourcing these tasks to specialized firms is another option.

The obvious caveat: this was a single case study. Its findings may not generalize to all primary care settings, especially urban environments or different patient demographics. The study's exploratory nature also means causal relationships remain unestablished.

It looked at just one rural family practice in Croatia. Can these results truly extend elsewhere? Deeper research is needed to confirm these findings and explore the reform's long-term effects.

The qualitative methodology involved interviews and specific practice data. While offering rich, in-depth insights into

operational changes, it inherently limits broad conclusions. A rural patient population likely has different health needs and access patterns than a diverse urban one. That difference could sway observed outcomes.

What does this all mean? Practices should conduct a thorough analysis of patient panel demographics, risk factors, and utilization patterns. This clarifies capitation revenue potential and pinpoints targeted intervention opportunities. Standardized protocols for preventative care services also ensure consistent delivery and guideline adherence.

Workflow optimization is essential. Streamlining administrative processes minimizes staff burden. Consider using electronic health records (EHRs) and other technology solutions. Closely monitor revenue streams and expenses, particularly the impact of capitation and fee-for-service payments. Ongoing staff training on payment model intricacies and best practices for panel management and preventative care delivery is also crucial.

But the ultimate question remains: Can a small, rural practice truly thrive under these complex, mixed payment models without substantial external support?

The Croatian experience underscores the ongoing challenge of balancing financial sustainability with quality patient care in primary care settings. While the reform aimed to incentivize preventative care and cost control, the administrative complexities and the need for sophisticated panel management highlight potential pitfalls for practices without robust infrastructure or support. This case study, despite its limitations, offers valuable insights into the practical realities of implementing mixed payment models.

Future research should expand beyond single-practice, rural settings. Larger, multi-site studies encompassing diverse urban and suburban practices are needed to assess generalizability. Longitudinal studies are also crucial to understand the long-term impact of such reforms on physician burnout, patient outcomes, and overall healthcare system costs. Furthermore, exploring the role of digital health tools and artificial intelligence in mitigating administrative burdens and optimizing preventative care delivery within these models warrants investigation. To further explore the clinical foundations essential for adapting to primary care reforms and optimising patient outcomes, we recommend consulting the Oxford Handbook of Clinical Medicine.

#### CLINICAL IMPLICATIONS

Croatia's payment reform dictates a new reality for primary care. Practices must now proactively manage patient panels, balancing volume with quality. Preventative care is no longer optional; it is tied directly to revenue. This shifts the clinical focus.

The administrative burden is significant. Clinicians find themselves navigating complex billing and reporting, diverting time from patient care. Technology investment becomes less a luxury, more a necessity.

Ignoring these shifts means risking financial stability. Patient outcomes could also suffer from rushed appointments or missed preventative screenings. Adaptability is key for survival.

Ultimately, the success of such reforms hinges on more than just payment structures. It requires robust support for practices to navigate the new administrative demands and clinical expectations.

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## REFERENCES

1. Organization for Economic Co-operation and Development (OECD). (2020). Health at a Glance 2019: OECD Indicators. Paris: OECD Publishing.
2. Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. The Milbank Quarterly, 83(3), 457-502.
3. doi:10.1111/j.1468-0009.2005.00409.x US Preventive Services Task Force. (2023). Recommendations. Retrieved from <https://www.uspreventiveservicestaskforce.org/uspstf/recommendations>
4. Goodman, D. C., Fisher, E. S., & Chang, C. H. (2003). The care of patients with chronic illness. The Dartmouth Atlas of Health Care. Chicago, IL: AHA Press.

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