Layers appear to be a crucial characteristic of disability policy structure. Disability policy functions within three models, that are diverse by its understanding of a problem (what disability is and who is a person with disability, how is that person approached, and what’s general policy orientation), of goals (purposes of state interventions), and in implementation (what sectors are dominant, and what instruments are crucial). Oldest model is medical model of disability policy making that gets new layers of goals, understandings, instruments and sectors by social model, and that human rights model. Symptomatic is the fact that newer aspects of policy making do not completely dismantle older features, but change them a bit and mostly coexist. So disability policy changes form “pure” social policy to identity policy.

Is this structure the result of low barriers to authoritative policy change and high barriers to internal policy conversion? This question will be researched on the case study of Croatian disability policy. Research approach will be inspired by historical institutionalism, and policy change will be traced from Croatian independence in 1990 till today. Research will try to trace all potential features of policy change: political regime transformation and democratic consolidation, international actors’ influence, NGO pressure influence, institutional redesign and creation of new ministry, etc. The aim is to help in revealing necessary aspects of theoretical concept of policy layering.

Key words: layering, disability policy, regimes of policy making, factors of policy change, Croatia
Introduction
The aim of this paper is to enlighten and reconstruct specific process that ends-up with policy layers, to help in revealing necessary aspects of theoretical concept of policy layering. So, the main purpose is to be a part of the refinement of this new theory of policy change. Is layering really the result of low barriers to authoritative policy change and high barriers to internal policy conversion (Hacker, 2004:248)? The concept is applied, within a case study, on the development of Croatian disability policy from Croatian independence in 1990 till today, as layering appears to be a crucial source of its dynamic. Researched question of the paper is about distinctive characteristics of the process of policy change in chosen sector. Methodologically, paper is inspired by broad approach of historical institutionalism and uses historical and qualitative analysis to extract features of Croatian disability policy change. Those are then compared to factors that are in the literature stressed out as ones that enhance layering.

Theoretical framework
Public policy research differs by the basic phenomena it wants to explain – policy variations or policy change (John, 1998:12-20). With the 'policy variation branch’ research tries to detect similarities and differences among more sectors – same sectors in different countries or different sectors in one country. On the other hand, studies on policy change are about describing and explaining (in)stabilities within one sector. Those studies dominate in policy research, as most of all work written on public policies is devoted to one policy sector (Colebatch, 2004:80). This paper is also within ‘policy change approach’.

Policy change or transformation is mostly differed by its intensity, degree or scope and by its velocity or tempo. So it could be gradual, steady and slow or rapid and abrupt. Also it could be normal, paradigmatic or incremental (Howlett, 2002:241-243; Loughlin, 2004:145-146; van der Heijden, 2010:2). Newer approach to policy change is an attempt to develop more profound concepts of its understanding that are focused on the form or pattern of the change. Examples of those are policy drift, policy replacement/displacement/revision, policy conversion and policy layering (Bélard, 2007; Hacker, 2004; Parker, Parenta, 2008; Thelen, 2003; van der Heijden, 2010).

Policy displacement (or revision or replacement, in some literature) connotes policy change in which new models of policy making completely supplement existing ones (van der Heijden,
2010:5). Even if this kind of understanding of policy change is quite present in policy literature as clear ideal type, it’s probably hard to find many “pure” empirical cases. Policy drift and conversion are more broadly present in practice and two terms are quite similar. Policy drift refers to a situation when old model of policy making persists, but its effects change because of environmental changes in socioeconomic conditions and the lack of adjusting to them (Béland, 2007:22; Hacker, 2004:246—249; van der Heijden, 2010:4-5). “Drift is characterized by the absence of updating existing institutions to changing circumstances“ (van der Heijden, 2010:5). Policy conversion explains policy change that occurs when existing policy model is used for new purposes – same institutions are employed for new goals (Hacker, 2004:246; van der Heijden, 2010:5). New goals or new actors alter the role or core objectives of some existing policy model (Béland, 2007:22). Drift and conversion differ as within conversion the change is in implementation process and within drift in outputs and overall effects (van der Heijden, 2010:5).

Policy layering refers to those policy changes in which new elements are attached onto old stable ones, without replacing them, but gradually transforms their status and structure (Béland, 2007:22; van der Heijden, 2010:3). Layering, simplified, is about adding agency, structure or both agency and structures to existing model of policy making (van der Heijden, 2010:3). This paper examines concept of policy layering with the empirical research of Croatian disability policy. There are more factors of change or reasons underlying layering. They could be, for the simplicity of empirical application, understood more broadly as characteristics of the change process through layering.

I’ve extracted seven characteristics of policy change through layering from literature. I have to note that they are not mutually exclusive and systematized, but often overlap. Mostly mentioned is the obvious one – (1) agency of policy actors (eg. Hacker, 2004:246). Policy changes could occur as mere coincidence, accidently, but also intentionally, as result of a conscious process and efforts of actors. Also, (2) internal policy structure, its characteristics, goals, feedback, is an important factor of policy change (Hacker, 2004:246). Both features are quite general and expected, so here are some more specific ones. (3) Level of implementation discretion is also stressed out as important driver of change. Higher the discretion to apply the rules is, also is higher the possibility of internal, non-formal policy change (Hacker, 2004:247). Then, if a policy has (4) stable constituency, a target population in a form of large-scale organizations and politically efficacious support coalitions, that is an important factor
within the change of that policy (Hacker, 2004:247). Also, partisan balance that characterise political system and especially (5) result of electoral competition play an important role (Béland, 2007; Hacker, 2004:247). Further, basic decision rules and distribution of decision-makers’ preferences shape level of (6) status-quo bias and “weight” of veto-players (Hacker, 2004:247). (7) Ideational process is last feature. Ideas, understandings, beliefs and assumptions that actors hold – theirs policy paradigms ant paradigm shifts – especially show the direction of change (Béland, 2007:23-24; Parker, Parenta, 2008:610-613).

Hacker sums up all named factors into two main variables. Firstly, it’s all about the question “how easily can these actors achieve their aims through the existing framework“ and, secondly, “how costly would it be to replace it with a policy more closely tailored to the ends they desire” (Hacker, 2004:246). Answers to those two questions differentiate among modes of policy change (see Table 1). Policy layering happens when there are low barriers to authoritative policy change. This means that basic decision rules (bias to status-quo) and partisan balance (results of electoral competition) don’t strongly block formal policy change (factors 5 and 6). This opens space for the introduction of new element of policy making – “context permits the creation of new policies” (Hacker, 2004:248). This is where layering overlaps with revision of policy, through reform, replacement or termination. But differently from revision, layering is characterized with high barriers to internal policy change (Hacker, 2004:248). In general, hardened internal policy structure is an obstacle to policy change (factor 2). One important aspect of this obstacle could be vested interests, or strong and big target populations of old policy regime (factor 4). Also, low level of implementation discretion lowers the space for change through layering (factor 3). Policy actors and ideational process are not neatly fitting into this scheme. But still, to what extent could this be found in the process of change of Croatian disability policy?
Table 1: Modes of policy change

![Table 1: Modes of policy change](image)


**Development of Croatian disability policy – the chronology**

Policy for persons with disabilities (PWDs), or shortly disability policy, is shaped and implemented for the benefits of around 10% of population in world and in Croatia.\(^1\) It is getting more and more importance in the last 30 years in many western countries, form many international organizations and in Croatia. Disability is one of the most complex and ambiguous issues in health research (Altman, 2001:100). PWDs are the most uneducated

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\(^1\) There are about one billion people experiencing disability today in the world (see *World report on disability*, available on: [http://www.who.int/disabilities/world_report/2011/en/index.html](http://www.who.int/disabilities/world_report/2011/en/index.html), accessed on 14\(^{th}\) June 2013). In Croatia, by the census done in 2011 and Register of PWD, there are 518 081 PWD, or 12,1% of whole population (see *Report on people with disabilities in Republic of Croatia*, available on: [http://www.hzjz.hr/epidemiologija/kron_mas/invalididi11.pdf](http://www.hzjz.hr/epidemiologija/kron_mas/invalididi11.pdf), accessed on 14\(^{th}\) June 2013). But target population is much bigger, as consequences of disability are directly affecting social surrounding of PWDs – family, friends and work colleagues. Also, it is a target population with elastic border line. Only 6% of PDWs have disability from birth (Žiljak, 2005:20), so anybody could become a part of the target population.
group in society. Also, they have much lower economic opportunities and are quite often unemployed.\(^2\) PWDs also have the highest rates of poverty in society. The cause of theirs poverty is, beside unemployment, much higher life expenses due to disability. All of this makes them disempowered and isolated part of the community, so they need some extra support from the state. Disability was not a social category before 18\(^{th}\) century even though impairments were broadly present (Braddock, Parish, 2001:12). In Croatia all the way to the 20\(^{th}\) century disability was neglected topic, and PWDs were hidden within families (Benjak, 2009:11). So disability policy develops in the last hundred years.

Croatian disability policy emerged as a part of broader social policy, which could be interpreted as developed through five main periods, and with four critical junctures. Croatia was a farmers’ country and some rudimentary laws on social security were introduced by the end of 19\(^{th}\) century. Also, in the 19\(^{th}\) century many humanitarian organizations were formed that were substituting state action in the area of social policy. Around First World War (first critical juncture) intensive care for war victims and endangered poor population developed, and PDW were included. Until the Second World War there were some homes, clubs and schools for blind and deaf organized, but not financed by the state but as charities (Puljiz, 2008:4-8, 14-19, 2009:14).

The period after formation of socialist Yugoslavia/Croatia (second critical juncture) was time of building huge social infrastructure and state became sole provider of social care. PDWs were important target population of social policies (Puljiz, 2008:19-23).\(^3\) Quite important characteristic of the disability policy in that period was the segregation system and the division of care for PDWs and general population, with some small exceptions after 1980s in the education for persons with mild disability (Urbanc, 2006:324). Charities and other civil society organizations, especially Catholic Church, and theirs activities were severely limited and under strong supervision of the state (Puljiz, 2009:15). But some community organizations had greater significance and those were representing interests of disability and sick people (Bežovan, Zrinščak, 2007:31-32; Bežovan, 2008:399). NGOs of the PWDs are one of the oldest parts of civil society in Croatia, as some today present association of PWDs have 50 or 60 years of activity.

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\(^2\) The unemployment rate is several times higher among people with disabilities than the general population (Urbanc, 2006:325).

\(^3\) Post-communist countries, for example Poland, Hungary, Slovakia, Czech Republic, are all characterized with large systems of institutionalization of PWDs, built in the period of communism (Holland 2007:545-546).
In the beginning of the 1990s (third critical juncture), with the independence of Croatia, so-called emergency social state was formed, due to mobilization of national resources to overcome economic and humanitarian crisis caused by war and first phase of post-socialist transition. Second part of the 1990s was marked by slow economic recovery and preparations for the social policy reform under the influence of World Bank and IMF. Reforms was directed towards reducing state expenditures onto social policies, especially on health and pension system, but this were important first steps towards so called social policy mix model (Puljiz, 2008: 27, 31-43, 48; 2009:15). The first part of the 1990s was also marked by the very important role of NGOs and international organizations that intensively worked in Croatia, and among them most developed were those NGOs within social policy sectors, because of the socialist heritage (Bežovan 2008:427; Puljiz, 2008:31-37). By the end of the 1990s, with the withdrawal of international financial sources from Croatia, civil sector was going through a crisis (Puljiz, 2009:15). After 2000 (fourth critical juncture) Croatia started to experience bigger economic growth rates. Also, the civil sector entered the period of stabilization. In Croatian social policy there was a redefinition of roles of actors in the direction of lowering state role and the growth of importance of market, families and NGOs (Puljiz, 2008:48, 52; 2009:15-16). The most important characteristic of this period is the Europeanization of Croatian social policy (Stubbs, 2008:372-375).4

After 2000 there was significant change in Croatian disability policy. Disability policy gained much in importance. This follows the trend in other European countries and at the EU level, with the so-called mainstreaming of disability policy within the broader framework of social policies. It also refers to the development of new regulations aimed solely at PWDs, and the fact that a number other regulations is now viewed through the perspective of PWDs (Mabbett, 2005).5 That is reflected in many international documents, among which the most important and novel is UN’s Convention on the rights of persons with disabilities (30th March

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4 Eastern European countries are hard to fit into Esping-Andersen welfare state typology, so Aidukaite proposes to introduce more factors in the research of those welfare states development, as: strong bureaucracy, policy actors from civil society, influence of international actors and globalisation, and Europeanization (2009:33-36).

5 Mainstreaming of Croatian disability policy is nicely reflected by the following quote from the interview with Croatian MP: "... there are groups that are currently fashionable, to say so brutally... Once were veterans and women ... Now this is a new area of ... I came into this house in 2002 and through these 9, 10 years, until recently disability was not at issue, but today it is. For example, when you have a law on public television, so the in the TV Council NGOs has to be represented and now PWDs NGOs must be represented also. Sometime we add prism to discuss not only the specific documents, because we voted in Strategy for PWDs, Law on the PWDs Ombudsman and the like ... but in these other laws this is inserted as a value”(Interview no. 2).
Last decade Croatia was marked by really intense regulatory activities in the area of disability policy. Since 2000 Croatia adopted by five important documents for PWDs: Law on Vocational Rehabilitation and Employment of Persons with Disabilities (2002); National Strategy for Unified Policy for Persons with Disabilities from 2003 to 2006 (2003); Declaration on the Rights of Persons with Disabilities (2005); Law on the Ombudsman for Persons with Disabilities (2007); National Strategy of Equalization of Opportunities for Persons with Disabilities 2007 to 2015 (2007), and additionally the law to ratify the UN’s Convention (2007). It should be emphasized that the new anti-discrimination law (2008) introduced disability as discriminatory basis. This is a very large restructuring of the regulatory framework in quite a short period of time.

Intent of this paper is to reinterpret the change in 2000 not as a clear critical juncture in Croatian disability policy but as change through layering. Results of explained trends in the approach to disability through history, and especially in the context of the development of disability policy in the last 25 years in its post-independence phase, could be analysed by three models of disability policy making – medical model, social model and human right model. They will be used to describe process of layering.

**Development of Croatian disability policy – the regimes**

Disability policy functions within three models of policy making. Those models are diverse by number of elements, characteristics of policy making. Firstly, models differ by understanding of a problem: what disability is and who is a person with disability, how is that person approached, and what the general policy orientation is. Secondly, there are different goals involved and models differ in how the purpose of state intervention is determined. And,

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6 Models of disability policy making were products of my PhD research (see Petek 2012) and the research project *Attitudes of members of representative bodies on political dimensions of disability and inclusion of people with different disabilities in political life*, done by Faculty of Political Sciences Zagreb for Croatian Government. Research projects were based on content analysis of 12 Croatian documents. Then, the study included 16 semi-structured interviews of actors involved in the creation of Croatian disability policy, processed and analysed using open coding. Extra four interviews were done in a second round. The analysis also included data from a survey with 386 members of representative bodies at all levels of government (municipal, city, county, central government) about their views on the political dimensions of disability. Also, there was some participant observation of workshops and meetings of policy actors. Representational analysis was used to access documents, workshops, online materials, and interviews from both rounds (Petek, 2011, 2012b). The scheme was built up by using all named data and literature overview.
in the end, thirdly, model of disability policy making differ in implementation – what adjectival policies or sectors are dominant and what policy instruments are crucial. Those elements form medical, social and human rights model of disability policy (see Table 2).

Table 2: Regimes of disability policy

<table>
<thead>
<tr>
<th>A. PROBLEM</th>
<th>Models of disability policy</th>
<th>B. GOALS</th>
<th>C. IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understanding disability as…</td>
<td>Medical model</td>
<td>Medical model perceives disability as physical or intellectual impairment because of which a person that has it diverges from average population and cannot function “normally”. This is why it is also called a statistical model (Igrić, 2004). So, in medical model disability is a medical condition that can be treated with therapy. The goal of rehabilitation is to change...</td>
<td>Care for PWD</td>
</tr>
<tr>
<td>2. Who is PWD?</td>
<td>Broad social model</td>
<td>Impairment + social barriers</td>
<td>Equality of PWDs</td>
</tr>
<tr>
<td>3. Approach to PWD is…</td>
<td>Narrower social model</td>
<td>Impairment + social barriers</td>
<td>Empowering PWDs</td>
</tr>
<tr>
<td>4. Focus on…</td>
<td>Human rights model</td>
<td>Impairment + social barriers</td>
<td>Social inclusion</td>
</tr>
<tr>
<td>Individual / on PWD</td>
<td>Impairment</td>
<td>Fellow citizen with disability</td>
<td>Antidiscrimination regulation; Quotas; Public advocacy campaigns; Building standard regulations</td>
</tr>
<tr>
<td>Society / environment of PWD</td>
<td>For improving life conditions</td>
<td>Citizen</td>
<td></td>
</tr>
</tbody>
</table>

PWD to make it more “normal” (Urbanc, 2006:322). Hence, PWD is primarily a patient (Pfeiffer, 2001:30; Žiljak, 2006:255). She is also the poor and needs social transfers from the state and special public services (especially accommodation) from state institutions. State intervention is primarily understood societal costs (Fischer, 1995). In medical model disability policy consists of parts of health and social care policy with the main purpose of providing basic care for PWDs. This model is based on compassion of the society and helplessness of PWDs.

Social model develops through critique of medical model. Into the definition of disability, onto impairment, there is social dimension added. “Normal” functioning is prevented not just by impairment, but also by socially placed physical barriers and oppressive and discriminatory social structures as mental and communication obstacles (Igrić, 2004:155). So the PWD is not only the result of the deficit of the individual, but also by deficit of the community. Consequently PWD becomes seen as a fellow citizen with disability whose life conditions and social context should be improved through environmental modifications. Main goal of disability policy becomes equality of PWDs. Basic values starts to be social inclusion – idea that community is not whole until all its members are welcome and included, with all their differences (Urbanc, 2006:323). The purpose of state interventions is to dismantle social isolation of PWDs. New sectors become included into disability policy, especially antidiscrimination mechanisms and policies that promote freedom of movement. With the antidiscrimination regulation public advocacy campaigns are used, or quota systems. Also, special standards for building are set.

Finally, human right model is developed not as critique to the social model, but as an addition to it. Legal equality, ensured by the described social model, is not sufficient to produce social inclusion in practice. Complementarity of two models in is manifested as they share the definition of disability. Human rights model is really “putting” back focus on a PWD, on individual citizen. So, disability policy should also be developmental to enhance the capacities and potentials of PWDs to empower them (Igrić, 2004:151-155). New important sector within disability policy becomes education (Žiljak, 2005), but also culture policy for example. Political rights of PWDs come into focus. Empowering of PWDs is chased by instruments as educational workshop or assistants, sign language translators or with deinstitutionalization and promotion of community living. Human rights model with the
previously presented narrower social model makes “whole” or broad social model, so together they create one policy regime (Howlett, 2009).

Models have developed as they were presented – medical, then narrower social, then human rights model (see the arrow in Table 2). Medical model is present in Croatian disability policy until 2000 and a broader social model develops after 2000. On the first look the shifts in models seem as reform, almost revolution – a paradigmatic radical change of policy making. The change was introduced by intense regulatory activity, by broad formal policy change. But with a closer look, it is obvious that new elements haven’t dismantled old ones, but changed them a bit and mostly coexist with them. That could be explained through three basic arguments.

Firstly, transformation of disability policy is primarily about its spreading onto new sectors – form health and social care to education, labour market, culture, sports, building, etc. All added sectors are getting additional focus on PWDs and being connected with this target population. In general, disability policy changes form “pure” social policy to multi-sectoral identity policy. It becomes a mix of social protection, integration into labour market and civil rights (Waldschmidt, Lingnau, 2008:7). So it is primarily spreading out of disability policy through layering.

Secondly, medical model could never be completely overcome as PWD is always a citizen but as well a patient. PWDs will not stop to have specific requisites from health system and higher life expenses than general population. With education and employment of PWDs, and higher level of independence, their needs for some special support and help system does not end (Urbanč, 2006:330-331). The eventual paradox that by employing PWD they lose social rights is already criticized by emphasizing dangers of radical social model (eg. Shakespeare, Watson, 2000). With the introduction of social model in Croatia social transfers to PWDs were kept in place. Likewise, huge public sector of health and social care institutions never stopped delivering “classical” services to PWDs. The analysis of policy instruments of Croatian disability policy showed that all types of instruments from so called NATO scheme are presents (Howlett, 2009:82). Categories of treasure/transfers and organization/public services did not extinct (Petek, 2012b:210-213).
Thirdly, here are two examples how layering is characterized by gradual transformations of older forms of policy making. Empowering from human rights model penetrates into medical model. The health care system in Croatia is established on the principle of equally to all under the same conditions. "However, when it comes to people with disabilities, practice has shown that this principle cannot be implemented literally. Namely, to people with disabilities achieve the same level of competence and independence as people who are not affected by such a problem, in specific situations, they need to be provided with a higher level of health care" (Znaor, Janičar, Kiš Glavaš, 2003:7). Also, there’s a change in the practice of measuring disability, which is the basis for consuming different rights that system provides. Old approach of measuring was resulting with the percentage of impairment. Now Croatia is in process of creating Uniform list of functional capabilities, added to Uniform list of impairments, and it’s in trial application (Benjak et al, 2012). The idea is to measure not solely deviation from normality but (remaining) abilities of PWDs – on their powers. So, layers appear to be a crucial feature of disability policy structure.\(^7\)

**Factors of development of Croatian disability policy**

Last part of the analysis re-examines development of Croatian disability policy to highlight features of its change. The aim is to stress out all novel characteristics of the process of disability policy making in Croatia after 2000. Intent was to create, by re-coding all available data on the question “how change emerged”, as much as possible attributes of the change in question to compare the list of findings with initial theoretical assumptions on factors of policy change through layering. There are six main features of Croatian disability policy change found.

(1) *Political regime transformation and democratic consolidation.* According to a survey on the state of democracy of Freedom House and its annual reports *Freedom in the World*, Croatia from 1991 until 2000 belonged to the group of partly democratic states, due to defects in the full realization of political and civil rights of citizens. Since 2001 Croatia is classified within the group of fully democratic state, which means that there are not serious shortcomings in the implementation of political and civil rights.\(^8\) In 2000, when left-wing

\(^7\) Previous research showed that there's dominance of narrower social model and some neglect of PWDs activity and human rights model instruments. The change of Croatian disability policy is still primarily focus on social context and community (Petek, 2011; 2012:171-242). But two (or “two-and-a-half”) layers, instead of “full” three, does not change this basic argument of the paper.

\(^8\) More details on: http://www.freedomhouse.org/report-types/freedom-world (access on 15\(^{th}\) June 2013).
coalition got into power, Croatia had the first change of government after independence, which was a quite novel electoral result. By breaking status-quo, this opened up space for new policy actors, new agencies of existing actors, bigger influence of old actors, and especially space for non-state and international actors. After 2000, a more positive climate for the activities of civil society organizations was created, and the government increasingly started to respect the voices of non-state actors. Attitude that civil society is a very important factor in the development of democracy matured (Šalaj, 2006).

(2) International actors’ influence and policy transfer. Change in Croatian disability policy could be marked as policy transfer (Dolowitz, Marsh, 1996; 2000). Influence of international actors within Croatia was high. Also, domestic policy actors, state and non-state, intensified their cooperation on the international scene. Analysis of goals of disability policy in Croatian documents and interviews with actors showed that, among those goals stressed out in models of disability policy making, there’s additional one. One of the crucial purposes of changes in disability regulation is to make Croatian legal system coherent with international and European standards and to transfer different international documents into domestic regulatory frame (Petek, 2011, 2012:194-201).

(3) Civil society transformation and NGOs’ activity. I’ve already mentioned that NGOs within disability movement are one of the oldest parts of Croatian civil society. And a big one, too. It is estimated that in Croatia there are more than 300 associations gathering PWDs or providing them with assistance. There are two basic types of NGOs in Croatian disability policy: big and old umbrella organizations or federations of organizations, associations, that are of the socialist era, with a stable state funding, but generally no new initiatives; and newer, smaller more innovative NGOs, often organized on the principles of self-help, that promote innovation, mobilize membership and local resources (Bežovan, Zrinščak, 2007:168). First ones created a strong block for preservation of acquired privileges and positions (from medical model). Second ones promote newer aspects of social model of disability policy. Often sides get into conflict, even on the issue of “correct” terms. But both parts influence disability policy making. Analysis of documents in the aspect of policy instruments showed the existence of special section on cooperation and its importance for the implementation of disability policy. It’s prescribed that formal actors on national level should cooperate and

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9 With the words of actors: “When it comes to people with disabilities, decisions are always made because it is going to solve something for Europe” (Interview no. 15).
consult with local communities, families, labour market, and especially NGOs that work in benefit of PWDs or are representatives of PWDs. Interviews confirm that (Petek, 2012b:206-207; 211). 11 representatives of associations of PWDs’ NGOs are members of Commission for persons with disability, advisory and expert governmental body, which is formalized aspect of policy network. Ombudsman for PWDs stresses out that the NGOs were the key accelerator that have changed paradigm of understanding disability in Croatia and introduced non-discriminatory vocabulary.  

(4) Creation of new ministry. Main ministries for disability policy were Ministry of work and social care and Ministry of health (2000-2003) that in 2004 combined into Ministry of health and social care. But in 2004 a new ministry was formed – Ministry of family, war veterans and intergenerational solidarity (short acronym MF). MF was a specific ministry as it is not a quite standardized governmental department in the world, but it was formed to mirror political expertise of vice prime minister at that moment (later she became the prime minister). The ministry was deactivated in 2011 with new coalition in power. But for several years MF was set as a key coordination body for disability policy and disability strategy implementation. It is interesting that this ministry was almost exclusively guided the social model. On the one hand, the reason for this is that it was open, unoccupied space. On the other hand, new ministry had no "burden" of managing large, complex, and with many problems limited public sectors, such as the health system and social care system. Although this institutional design created incoherence in the management of social policy, a kind of competition between the two ministries and the partial overlap of their functions (Puljiz, 2008:48), it have opened the possibility of faster transformation of disability policy.

(5) Incoherence and diversity. Analysis of policy instruments within Croatian disability policy showed that best label to describe implementation of Croatian disability policy is incoherence and diversity. In interviews with actors the notion of the unsystematic implementation was a crucial critic of the disability policy making, as this policy changed unevenly across country.

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10 Interview in magazine Civilno društvo, 2009: 29.
11 Germany has a Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (see http://www.bundesregierung.de/Webs/Breg/EN/FederalGovernment/Ministries/BMFSFJ/_node.html).
12 MF was transformed into Ministry of war veterans, and other jurisdictions were putt back onto Ministry of social policy and youth. For details on the change of all ministries of all Croatian government from 1990 to 200 see Petek 2012a.
13 Actors recognize this feature of MF: "MF is totally open and fastest adapts to the needs of people with disabilities. I do not say because this research for them" (Interview no. 15).
PWDs as target population are highly diverse so individualization to specific ‘time and place circumstances’ is necessary. Still, great regional unevenness was emphasized, especially a huge gap between cities, especially successful disability policy of the capital, and rural areas in the provision of services. Whole policy is, by the evaluation of actors, not coordinated enough and too dependent in results on the effort of eager individuals who force changes.

(6) Political correctness and discourse. Dipper change of the discourse, as broad awareness of citizens and political elites on new trends in understanding disability, had just begun and did not progress far. But the change in linguistic aspect of the discourse was fast and thorough. Political correctness in terminology about disability really marks this policy. All documents after 2000 have politically correct new terms according to social model. All interviewed actors, especially politicians, almost never “made mistake” in this aspect. So, person with disability became a standard. There’s almost no more disabled, or handicapped used. Also, person with intellectual disability mostly substituted mentally retarded (as a long time ago this term substituted idiot, cretin or moron).

Conclusion
Paper examined Croatian disability policy from 1990 till today and its change. This period could be divided into two phases – before and after 2000. Crucial aim of the paper was to reinterpret 2000-change not as a clear critical juncture, but as a change through layering. Three models of disability policy making represent the layers in its structure. Further on this assumption the question on characteristics of disability policy change was posed and six main featured occurred from data: (1) political regime transformation and democratic consolidation; (2) international actors’ influence and policy transfer; (3) civil society transformation and NGOs’ activity; (4) creation of new ministry (5) incoherence and diversity; (6) political correctness and discourse. Those mostly overlap with theoretical factors for determining kind of policy change.

Policy actors are crucial feature of process of change in both, theoretical expectations and empirical example. Layering should be marked with are low barriers to authoritative policy change and this was quite evident in Croatian disability policy. Democratic consolidation and new electoral results (change of partisan balance and coalition in power) and the disappearing of status-quo bias opened space for big regulatory change of Croatian disability policy. Also, layering is characterized with high barriers to internal policy change. Croatian disability
policy definitely has strong constituency in a form of traditional PWDs associations that block dismantling of old policy elements. This is also consistent with the theory. The incoherent and unsystematic implementation of Croatian disability policy is a result of significant implementation discretions and this is the only factor “inversely proportional” in theory and in our case study findings. Discourse change reflected in high levels of political correctness in Croatian disability policy is closely related to factor of ideational process, which shows direction of change.

In the end, most important finding in the case study of Croatian disability policy that is completely overlooked in theoretical frame is policy transfer. Policy transfers could be important driver of change, through cooperation of national actors with international actors; or by direct agency of international actors within some national policy; or by setting international standards as a goal of national policy making. This factor highly gains in importance within smaller countries and in countries trying to enter or already members of international integrations. Europeanization is one of those processes with great influence. Often Europeanization fosters fast formal/regulatory policy change that is not accompanied by the change in policy implementations. This should definitely be more analysed as a factor of policy layering.

REFERENCES


