

THE LAYERING OF DISABILITY POLICY: THE CASE OF CROATIA

Abstract. The paper examines the concept of policy layering by conducting a case study of Croatian disability policy. The analysis is structured around three aspects of disability policy change: critical junctures in its development; layering models or regimes of policy-making; the factors driving change in Croatian disability policy since 2000. Two main findings distinguish the Croatian case from the assumptions made in theory. The factor of implemental discretion was 'inversely proportional' in theory to what was found in the case study. Further, the strong influence of policy transfer and Europeanisation seen in the case is completely neglected by the concept of layering.

Keywords: policy mixes, gradual policy change, critical junctures, policy regimes, persons with disabilities, policy design, policy networks

Introduction

Public policies around the world are becoming mixes of different policies. Their contents are changing, new problems and issues are arising, policy designs are developed at higher levels, and networks of various actors make the game more complicated. Layering adds to the complexity of empirical phenomena and theoretical explanations of contemporary public policies. It is this intriguing new policy feature that is the research subject of this paper.

Public policy research differs according to the basic phenomena it seeks to explain – policy variations, similarities and differences among several sectors, or policy change and (in)stabilities within a single sector (John, 1998: 12–20). Policy change studies dominate in the area of policy research as nearly all work on public policies is devoted to one policy sector (Colebatch, 2004: 80). This paper also falls within the 'policy change approach'. Policy change chiefly varies by its intensity, degree or scope along with its velocity or tempo. This means it can be gradual, steady and slow or rapid and abrupt. It can also be normal, paradigmatic or incremental (Howlett,

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2002: 241–243; Loughlin, 2004: 145–146; van der Heijden, 2010: 2). The aim of this paper is to shed light on the specific phenomenon of policy layers to help reveal necessary aspects of the theoretical concept of policy layering, a new theory of gradual policy change. Is, as Hacker (2004: 248) asserts, layering truly the result of low barriers to authoritative policy change and high barriers to internal policy conversion?

The concept is used in a case study design on the development of Croatian disability policy. The analysis focuses on the last 20 years when layering appears to have been a crucial source of the dynamics of disability policy. The research question concerns distinct factors in the process of changing policy in a chosen sector. Methodologically, the paper is inspired by historical institutionalism to contextualise the case. I then use qualitative analysis to extract layers of disability policy regimes and features of Croatian disability policy change. The final results of the empirical analysis are compared with factors the literature identifies as factors that enhance layering.

The paper starts by explaining the theoretical and methodological framework. The following empirical analysis is organised in three parts: a description of the development of disability policy, marking out the critical junctures, a presentation of policy regimes within contemporary disability policy, succeeded by analyses of factors that have influenced change in Croatian disability policy since 2000. The concluding remarks briefly summarise the results and highlight some interesting findings of the paper.

Theoretical framework

Studies of policy changes dominate policy research. A newer approach to policy change brings an attempt to develop more profound concepts of its understanding that focus, besides the scope and velocity of the change, on its form or pattern. Examples of these new concepts are policy drift, policy replacement/displacement/revision, policy conversion and policy layering, with many explanations and applications in the policy literature (Béland, 2007; Daugbjerg and Swinbank, 2015; Feindt and Flynn, 2009; Hacker, 2004; Kay, 2007; Kern and Howlett, 2009; Parker and Parenta, 2008; Rocco and Thurstone, 2014; Thelen, 2003; Thielman and Tollefson, 2009; van der Heijden, 2010, 2011; Shpaizman, 2014). Policy displacement connotes policy change in which new models of policymaking completely supplement existing ones (van der Heijden, 2010: 5). Some studies denote this kind of major change a critical juncture. The other three types of change are examples of incremental or gradual policy change. They usually produce complex arrangements of instruments, goals and other policy elements or so-called policy mixes (Kern and Howlett, 2009), especially layering, which is the area I am concentrating on here.

Policy layering refers to gradual policy changes whereby new policy elements, particularly goals and instruments, are attached to old, stable ones, yet without replacing them and instead gradually transforming their status and structure (Béland, 2007: 22; Kern and Howlett, 2009; van der Heijden, 2010: 3, 2011; Shpaizman, 2014: 1039). Layering is about adding agency, structure or both agency and structures to an existing policymaking model (van der Heijden, 2010: 3). The literature refers to several factors of change or reasons underlying layering, of which I have extracted seven. I note they are not mutually exclusive and systematised, but often overlap.

The factor of policy changes most commonly mentioned is obvious – (1) the agency of policy actors (Hacker, 2004: 246; Rocco and Thurstone, 2014). Policy can change as a mere coincidence, accidentally, but it is typically the intentional outcome of conscious efforts of actors. This factor is followed by (2) internal structure of a policy – its characteristics, goals, feedback and ambiguity (Kern and Howlett, 2009; Hacker, 2004: 246; Rocco and Thurstone, 2014). For example, fused and strongly interlinked goals and instruments might disable a change within a certain policy sector. While these two features are quite general and expected, there are also more specific ones. (3) The level of implemental discretion is also seen as an important driver of change. Where civil servants hold greater discretion, this increases the possibility of internal, non-formal policy change (Hacker, 2004: 247; Shpaizman, 2014). Further, (4) a stable constituency – a target population in the form of large-scale organisations and politically efficacious support coalitions – is an important factor (Daugbjerg and Swinbank, 2015; Hacker, 2004: 247; Rocco and Thurstone, 2014).

In addition, (5) the results of electoral competition and changes in the partisan balance play a considerable role (Béland, 2007; Hacker, 2004: 247; Kay, 2007). A new party or coalition in government, along with its new ideological preferences, can produce the so-called political will needed to force change. Further, (6) the institutional features of the political system, such as decision-making procedures, deeply influence policy change. Basic decision rules shape the level of bias given by the status quo and the ‘weight’ of veto players, both being important factors in change (Hacker, 2004: 247; Shpaizman, 2014). (7) The ideational process is the final factor I have extracted. Ideas, understandings, beliefs and assumptions that actors hold – their policy paradigms and paradigm shifts – especially show the direction of change (Béland, 2007: 23–24; Feindt and Flynn, 2009; Kay, 2007; Parker and Parenta, 2008: 610–613; Shpaizman, 2014).

Hacker sees all the mentioned factors as forming two main variables that differentiate modes of policy change: barriers to authoritative policy change and barriers to internal policy change (see Table 1). Policy layering happens when there are low barriers to authoritative policy change. This means

that basic decision rules and bias toward the status quo, the partisan balance and the results of electoral competition do not strongly block formal policy change (factors 5 and 6). This provides space for the introduction of new policymaking elements – “context permits the creation of new policies” (Hacker, 2004: 248). It is here that layering overlaps with the revision of policy via reform, replacement or termination.

Table 1: *MODES OF POLICY CHANGE*

		BARRIERS TO INTERNAL POLICY CONVERSION	
		High (Low levels of policy discretion, strong policy support groups)	Low (High levels of discretion, weak support coalitions)
Barriers to Authoritative Policy Change	High (Many veto players)	DRIFT (Transformation of stable policy due to changing circumstances)	CONVERSION (Internal adaptation of existing policy)
	Low (Few veto players)	LAYERING (Creation of new policy without elimination of old)	REVISION (Formal reform, replacement, or elimination of existing policy)

Source: Hacker, 2004: 248.

But, unlike revision, layering is characterised by high barriers to internal policy change (Hacker, 2004: 248). In general, a rigid internal policy structure is an obstacle to policy change (factor 2). One key obstacle is vested interests, big and strong target populations of the old policy regime (factor 4). Further, a low level of implemental discretion accompanies change occurring through layering (factor 3). Policy actors and the ideational process (factors 1 and 7) do not neatly fit into this scheme. Notwithstanding this, to what extent can they be detected in Croatian disability policy?

Methodological framework

To answer this question, my analysis considers three aspects: the development of disability policy, the models or regimes of disability policy, and the factors of disability policy change that produced the models. In the first part, the development of disability policy and its critical junctures emerged from a literature review. This aspect of the paper, inspired by historical institutionalism (Capoccia and Kelemen, 2007; Peters, 2007; Thelen, 1999), is not based on original data but relies on the available published descriptions of the chronological development of disability policy. Critical junctures were noted at points in time interpreted in the literature as entailing policy change where a new set of policy elements wholly supplemented the existing ones.

The models or regimes of disability policy in the second part are the result of original empirical research.¹ The empirical research is based on content analysis of 12 Croatian documents (for the list, see Appendix). The study then included 16 semi-structured interviews with actors involved in Croatian disability policymaking, that were processed and analysed using open coding. Four extra interviews were conducted in a second round.² The analysis also included data from a survey of 386 members of representative bodies at all levels of government (municipal, city, county, central government) about their views concerning the political dimensions of disability. There was also some participant observation during the workshops and meetings with policy actors. The scheme of the disability policy regimes was developed by using all the named data and literature overviews. Different policy elements, e.g. goals and instruments, were deduced from the material. The specific structure of their relations was then added to the models of disability found in the disability literature and regimes of disability policy were originally developed (Petek, 2011, 2012b).

For the purposes of this paper, I reassessed all the named data and the results are presented in part three of this paper. Primarily the interview transcripts and documents were coded, but observation memos and even a few answers to the survey questions were also used. The open-coding procedure was guided by the question “How did change emerge?”. With the first-level coding, all statements in answer to this question were extracted. In the second-level coding, all of these extracted statements were labelled. In the final, third-level coding, all of the labels were merged and grouped. This is how drivers of the change were extracted from the empirical material so as to allow a comparison of the initial theoretical assumptions regarding the factors of policy change occurring through layering.

The development of Croatian disability policy – chronology

The policy for persons with disabilities (PWDs) is shaped and implemented for the benefit of more than 10% of the world and Croatian population.³ It has grown in importance over the last 30 years in many Western

¹ This research was conducted as part of my PhD thesis (Petek, 2012b) and the project *Attitudes of members of representative bodies on political dimensions of disability and inclusion of people with different disabilities in political life*, performed by the Faculty of Political Science of Zagreb for the Government of the Republic of Croatia (see Petek, 2011).

² Interviews were conducted with: 6 MPs (from different political parties, some were members of disability NGOs, and two were persons with a disability), the Ombudsman, 5 civil servants (highly positioned in different ministries), 7 representatives of disability NGOs (from different disability alliances, some were members of the government Commission for PWDs), and 1 journalist.

³ About 1 billion people experience disability in the world today (WHO, 2011). The UN estimates that

countries, many international organisations, the EU and in Croatia.⁴ Disability is one of the most complex and ambiguous issues in health research (Altman, 2001: 100). PWDs as a group have the lowest level of education, much worse economic opportunities, are quite often unemployed and have the highest poverty rates. The cause of poverty, besides unemployment, is having much higher expenses due to their disability. This all works to disempower and isolate them within the community; therefore, they need extra support from the state. Disability was not a social category before the 18th century, even though impairments were broadly present (Braddock and Parish, 2001: 12). In Croatia, disability was a neglected topic and PWDs were hidden within families up until the 20th century (Benjak, 2009: 11). Disability policy has existed in the last 100 years.

Croatian disability policy emerged as part of broader social policy. Its development may be seen as involving five main periods, with four critical junctures. In Croatia, by the end of the 19th century, some rudimentary laws on social security had been introduced. Still, many humanitarian organisations were formed that substituted the activity of a social state. Around the First World War (the 1st critical juncture), intensive care for war victims and an endangered poor population developed, including PDWs. Prior to the Second World War, some homes, clubs and schools were organised for the blind and deaf, but were financed by private charities not the state (Puljiz, 2008: 4–8, 14–19; Puljiz, 2009: 14).

The period after the formation of socialist Yugoslavia and the Socialist Republic of Croatia (the 2nd critical juncture) was the time of building a huge social infrastructure, and the state became the sole provider of social care. PDWs were an important target of social policies (Puljiz, 2008: 19–23). Disability policy was mostly characterised by a system of segregation entailing a division for caring for PDWs and another for the general population (Urbanc, 2006: 324). Charities and other civil society organisations, especially the Catholic Church, were severely limited and under strong state supervision (Puljiz, 2009: 15). But some organisations held greater significance, especially those representing the interests of PWDs and other patients (Bežovan and Zrinščak, 2007: 31–32; Bežovan, 2008: 399). The non-governmental organisations (NGOs) representing PWDs are some of the oldest parts of civil society in Croatia, with some having been active for the last 50 or 60 years.

on average up to 15% of the world population lives with a disability (UN, 2017), and in Croatia, according to the Register of PWD there are 511 850 PWD, or 11.9% of the whole population (Benjak et al., 2017: 5).

⁴ *The UN Convention on the Rights of Persons with Disabilities from 2006 is a crucial international document in the field, but the WHO and the Council of Europe have also produced important action plans for PWDs. Still, the EU is the central policymaker in disability policy on the European level as the EU has already developed the third strategy for PWDs since 2000 and produces action plans for disability every 2 years (for details on international documents on disability, see Petek et al., 2017).*

At the beginning of the 1990s (the 3rd critical juncture), along with Croatian independence the so-called emergency social state was formed to overcome the economic and humanitarian crisis caused by the war and post-socialist transition, and the erosion of the old socialist system started. The second half of the 1990s was marked by a slow economic recovery and preparations for social policy reform influenced by the World Bank and IMF. Reforms were directed at reducing state expenditure on social policies, especially the health and the pension system, marking an important first step towards a so-called social policy mix model (Puljiz, 2008: 27, 31–43, 48; Puljiz, 2009: 15). The 1990s also saw the very important role and intensive work of NGOs and international organisations in Croatia, particularly the most developed NGOs in social policy sectors (Bežovan, 2008: 427; Puljiz, 2008: 31–37; Puljiz, 2009: 15).

Since 2000 (potentially the 4th critical juncture), Croatia has started to enjoy higher economic growth. In social policy, the roles for actors redefined in the direction of limiting the state's role and the rising importance of markets, families and NGOs (Puljiz, 2008: 48, 52; Puljiz, 2009: 15–16). The most important characteristic of this period was the Europeanisation of Croatian social policy (Stubbs, 2008: 372–375). Since 2000, there has been a significant change in Croatian disability policy. It has become considerably more important. This follows the trend seen in other European countries and the EU, with the mainstreaming of disability policy within the broader framework of new social policies. It also refers to the development of new regulations aimed solely at PWDs, and the fact that many other regulations were now viewed via the PWD perspective (Mabbett, 2005).⁵ This was reflected in many new international documents, with one of the most important being the UN *Convention on the rights of persons with disabilities* (30 March 2007). Croatia was the third country in the world (among 80) to sign the *Convention*, and the fourth to ratify it.

Since 2000, Croatia has been marked by intensive regulatory activity concerning disability policy. Croatia has adopted six documents important 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 Equalisation of Opportunities for Persons*

⁵ The mainstreaming of Croatian disability policy is nicely reflected in the following quote from an interview with a Croatian MP: "... there are groups that are currently fashionable, to say so brutally... Once were veterans and women ... Now this is a new area ... 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 in the TV Council NGOs have to be represented and now PWDs' NGOs must be represented also" (Interview no. 2).

with Disabilities 2007 to 2015 (2007), *National Strategy of Equalisation of Opportunities for Persons with Disabilities 2017 to 2020* (2017), and legislation to ratify the UN Convention (2007). It should be emphasised that the new anti-discrimination law (2008) introduced disability as a basis for discrimination. This entailed massive restructuring of the disability policy regulatory framework in quite a short period of time. Since 2007, there has been no new important regulation concerning PWDs, except for the new strategy since the last one expired.

The results of the explained trends in the approach to disability over history, and especially its development in the last 25 years in Croatia, may be analysed by considering three regimes of disability policymaking. A medical model, a social model and a human rights model will all be used to describe the outputs of the process of layering. The intent of this paper is to reinterpret the changes made since 2000 not as a critical juncture in Croatian disability policy but as changes occurring through layering.

Outputs of the developed Croatian disability policy – The regimes

Disability policy functions within three policymaking regimes. These regimes⁶ differ in a number of elements. First, the models vary in their understanding of problems: what disability is, who persons with disabilities are, how they are approached and what the general policy orientation is. Second, different goals are involved, and the models differ in how the purpose of state intervention is determined. Third, models of disability policy vary in implementation – which sectors are dominant and which policy instruments are crucial. These elements form the medical, social and human rights models of disability policy (see Table 2).

The medical model perceives disability as an impairment that limits average functioning – a medical condition that can be treated. The goal of rehabilitation is to change PWDs in order to make them more ‘normal’ (Urbanc, 2006: 322). Hence, a PWD is primarily a patient (Pfeiffer, 2001: 30; Žiljak, 2006: 255). She⁷ is also poor and needs state social transfers and special public services. State intervention is chiefly understood as societal costs (Fischer, 1995). Here, disability policy consists of parts of health and social care policy for providing basic care for PWDs, based on the compassion of society and the helplessness of PWDs.

⁶ Policy regimes are “relatively stable institutionalized forms of state and societal preferences, goals and instruments that help define these functions and shape the provision of societal goods such as transportation, housing or health” (Kern, Howlett, 2009: 392). The policy literature more often uses the term policy regime and disability literature models of disability. As disability policy regimes were developed on the idea of disability models, I use these terms interchangeably.

⁷ ‘She’ is used as a generic term for both sexes.

Table 2: REGIMES OF DISABILITY POLICY

		Medical model	Broad social model	
			Narrower social model	Human rights model
A. PROBLEM	1. Understanding disability as...	Impairment	Impairment + social barriers	Impairment + social barriers
	2. Who is a PWD?	The patient or/ and the poor	Fellow citizen with disability	Citizen
	3. Approach to PWD is...	Therapeutic	For improving life conditions	Developmental
	4. Focus on...	Individual / on PWD	Society / environment of PWD	Individual / on PWD
B. GOALS	5. The purpose of state intervention is...	Care for PWD	Equality of PWDs	Empowering PWDs
			Social inclusion	
C. IMPLEMENTATION	6. Dominant sectors are...	Health policy, social care policy	Antidiscrimination policy, freedom of movement and barrier removal	Education policy, culture policy, political rights, free time
	7. Key policy instruments are...	Social transfers for PWDs, public services in health system or social care system institutions	Antidiscrimination regulation; Quotas; Public advocacy campaigns; Building standard regulations	Workshops, educational assistant, sign-language translator, deinstitutionalisation and community living

Sources: Petek, 2011: 107; Petek, 2012b: 184.

The social model adds a social dimension to impairment in the definition of disability. 'Normal' functioning is prevented not just by impairment, but also by physical barriers and oppressive, discriminatory social structures (Igrić, 2004: 155). Therefore, the PWD is a result of the deficits of the community as well. She becomes a fellow citizen with a disability, whose life conditions and social context should be improved through environmental modifications. The main goals of disability policy become equality and social inclusion – the idea that the community is not whole until all of its members are welcome and included, along with all their differences (Urbanc, 2006: 323). New sectors become included in disability policy, especially anti-discrimination mechanisms and policies that promote freedom of movement. Public advocacy campaigns, quota systems, and special standards for building start to be used.

Finally, the human rights model is developed as an addition to the social model because, in practice, legal equality is insufficient to produce social inclusion. The complementarity of the two models is seen in their shared definition of disability. Through the human rights model, disability policy seeks to be developmental to enhance the capacities and potential of PWDs so as to empower them (Igrić, 2004: 151–155). Education is becoming an

important sector within disability policy (Žiljak, 2005), along with culture and the political rights of PWDs. Empowerment is achieved by instruments such as educational workshops or assistants, sign-language translators or with deinstitutionalisation and the promotion of community living. The human rights model and the narrower social model make for a broad social model; together, they create one broader policy regime.

The models were developed as they presented above the – medical model, the narrower social model, then the human rights model. The medical model was present in Croatian disability policy until 2000 and a broader social model has developed since 2000. At first glance, the shift in models seems to entail a reform, almost a revolution – a paradigmatic radical change, as it was a revision of policy. The change was introduced by intense regulatory activity and broad formal policy change. But after a closer look, it is obvious that the new elements did not put an end to the old ones, but instead changed them and they coexist. This can be explained by considering three basic arguments.

First, the transformation of disability policy is primarily about its spreading into new sectors – from health and social care to education, labour markets, culture, sports, construction etc. The disability policy changes are transforming a ‘pure’ health/social policy into a multisectoral policy. It is becoming a mix of social protection, labour market integration and civil rights (Waldschmidt and Lingnau, 2008: 7). Therefore, this is primarily disability policy stretching occurring through layering.

Second, the medical model can never be completely overcome as PWDs are always patients too. PWDs will not stop making specific requests of the health system and having higher life expenses than the general population. Once PWDs are educated, become employed and more independent, their need for special support and a help system does not end (Urbanc, 2006: 330–331). The eventual paradox that, when PWDs become employed, they lose their social rights, is criticised by emphasising the dangers of a radical social model (e.g., Shakespeare and Watson, 2000). With the introduction of a social model in Croatia, social transfers to PWDs were kept in place. Likewise, the huge public sectors encompassing health and social care institutions never stopped delivering the ‘traditional’ services to PWDs. The analysis of the policy instruments of Croatian disability policy showed that all types of instruments from the so-called NATO scheme are present (Howlett, 2009: 82). The categories of treasure/transfers and organisation/public services did not become extinct (Petek, 2012b: 210–213).

Third, here are two examples of how layering is characterised by the gradual transformation of older forms of policymaking. Empowerment from the human rights model is penetrating the medical model. The healthcare system in Croatia is established on the principle of equality for all on the same

conditions. “However, for people with disabilities to 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 et al., 2003: 7). Further, there has been a change in the practice of measuring disability, which is the basis for using the rights and services the system provides. The old approach to measuring results in a percentage level of impairment. Today Croatia, following international guidelines, also measures the functional capabilities of PWDs. The idea is to measure not just deviation from ‘normality’, but the (remaining) abilities of PWDs – their powers. We can conclude that layers appear to be a crucial feature of disability policy design.

Factors in changing Croatian disability policy

The last part of the analysis re-examines the development of Croatian disability policy to highlight the factors involved in how it has changed. The aim is to stress the drivers of the changes in disability policymaking in Croatia since 2000. Only the most recent critical juncture is analysed because incremental change analysis requires shorter periods of time to be examined. I found six main aspects of Croatian disability policy change within the process of the last transformation of this policy.

(1) *Political regime transformation and democratic consolidation.* In 2000, when a left-wing coalition came to power, Croatia saw its first change in government after independence, which was a quite novel electoral result. By breaking from the status quo, this opened up space for new policy actors, new agencies of existing actors, the greater influence of old actors and especially space for non-state and international actors. According to Freedom House’s *Freedom in the World* report on the state of democracy and its annual reports, from 1991 until 2000 Croatia belonged to the group of partly democratic states due to defects in the full realisation of the political and civil rights of its citizens. Since 2001, Croatia is classified in the group of fully democratic states, meaning there are no serious shortcomings in the implementation of political and civil rights.⁸ Since 2000, a more positive climate for the activities of civil society organisations has been created, and the government has increasingly started to respect the voices of non-state actors. The belief that civil society was a very important factor in the development of democracy became stronger (Šalaj, 2006).

(2) *International actors’ influence and policy transfer.* The changes in Croatian disability policy may be described as policy transfer. The influence

⁸ Freedom House in its yearly report for 2001 classifies Croatia as a new entry in the group of free countries “in which a broad range of political rights are respected” (Freedomhouse.org, 2001: 1).

of international actors, especially the EU, within Croatia has been high.⁹ Further, domestic policy actors, state and non-state, have intensified their cooperation with the international scene since 2000. The analysis of the goals of disability policy in Croatian documents and the interviews with the actors showed that, among those goals stressed in the disability policy regimes, there is one more. One of the crucial purposes of making changes in disability regulations has been to make the Croatian legal system harmonised with international and European standards and to transfer different international documents into the domestic regulatory framework (Petek, 2011; Petek, 2012: 194–201).¹⁰

(3) *Civil society's transformation and NGO activities.* NGOs within the disability movement are some of the oldest and biggest parts of Croatian civil society. It is estimated that in Croatia there are more than 300 associations for connecting PWDs or providing them with assistance. There are two basic types of NGO in Croatian disability policy: big and old umbrella associations from the socialist era, with stable state funding but generally without any new initiatives; and newer, smaller, more innovative NGOs, often organised on self-help principles that promote innovation and mobilise membership and local resources (Bežovan and Zrinščak, 2007: 168). The first ones have created a strong obstacle by seeking to preserve their acquired privileges and positions (from a medical model). The second ones have promoted newer aspects of the social model. Often the two sides have come into conflict, even on the issue of the 'correct' terms. However, both parts have influenced disability policymaking. Analysis of the documents shows an emphasis on the cooperation of formal actors on the national level with local communities, families, labour markets and especially NGOs. The interviews confirm this (Petek, 2012b: 206–207; 211). Seventeen representatives of PWDs' associations are members of the Commission for PWDs, a special advisory and expert governmental body which is a formal aspect of the policy network. The Ombudsman for PWDs stressed the NGOs were the key accelerator in changing the understanding of disability and introducing a non-discriminatory vocabulary (Beljan, 2009: 29).¹¹

(4) *The creation of a new ministry.* The main ministries for disability policy were the Ministry of Work and Social Care and the Ministry of Health

⁹ "When it comes to people with disabilities, decisions are always made because it is going to solve something for Europe" (Interview no. 15).

¹⁰ Documents often argue that "pursuing an active human rights policy derives from the adoption of key international documents as well as the contemporary standards in this area" (Government of the Republic of Croatia, 2007b: 1.1).

¹¹ Survey results show that 85.3% of Croatian MPs on the national and local level see PWDs and their NGOs as a crucial agent of change in disability policy (40.8% stressed PWDs' NGOs; 26.2% PWDs as individuals; 18.3% stressed the alliances of PWDs' NGOs).

(2000–2003), but in 2004 were merged to form the Ministry of Health and Social Care. Also in 2004, a new ministry was established – the Ministry of Family, War Veterans and Intergenerational Solidarity (MFWVIS). The MFWVIS was a specific ministry as it was not quite a standard governmental department, but was formed to mirror the ‘political expertise’ of the then deputy prime minister. The ministry was deactivated in 2011 by the new coalition in power.¹² But for several years the MFWVIS was the key coordination body for implementing disability strategy. It is interesting that this ministry was almost exclusively guided by the social model. On one hand, this was an open, unoccupied space. On the other, the new ministry did not have the ‘burden’ of managing large and complex public sectors with many problems, such as the health and social care systems. Although this institutional design created incoherence in the management of social policy, competition between the two ministries and a partial overlap of their functions (Puljiz, 2008: 48), it facilitated the faster transformation of disability policy.¹³

(5) *Incoherence and diversity*. Analysis of the policy instruments showed the best words to describe the implementation of Croatian disability policy are incoherence and diversity. This is a central feature of the internal structure of Croatian disability policy. In the interviews with the actors, the notion of unsystematic implementation was a crucial criticism of disability policy-making as this policy has changed unevenly across the country.¹⁴ PWDs as a target population are highly diverse so individualisation to specific ‘time and place circumstances’ is necessary. Still, great regional unevenness was emphasised – a huge gap in the provision of services between cities, especially the successful disability policy of the capital, and the rural areas. The whole policy is, in the evaluation of the actors, not coordinated enough and too dependent on the efforts of eager individuals who force changes.

(6) *Political correctness*. A deeper change within the discourse as citizens’ and political elites’ broad awareness of new trends in understanding disability had just begun and had not progressed far. However, the change in the linguistic aspects of the discourse were fast and thorough. Political correctness in the disability terminology really marks this policy. All documents since 2000 have new, politically correct terms according to the social model. All of the interviewed actors, especially politicians, almost never ‘made mistakes’ in this respect. Accordingly, a person with a disability

¹² MFWVIS was transformed into the Ministry of War Veterans, some jurisdictions were returned to the Ministry of Social Policy and Youth, today’s Ministry of Demography, Family, Youth and Social Policy. For details of all Croatian ministries from 1990 to 2000, see Petek, 2012a.

¹³ “MFWVIS is totally open and fastest adapts to the needs of people with disabilities” (Interview no. 15).

¹⁴ “We have seen so many immense differences depending on where a person with a disability lives in Croatia” (Interview no. 7).

became standard. There was almost no further use of disabled or handicapped. In addition, person with an intellectual disability is now mostly used instead of mentally retarded (as previously this term substituted idiot, cretin or moron).

Conclusion

This paper has examined Croatian disability policy and its changes. The concept of layering was seen in an interesting case study, providing some inspiration for further research. The crucial point of the paper was to reinterpret the change made in 2000 not as a critical juncture, but as a change occurring through layering. Three regimes of disability policymaking represented the layers entailed in its policy design. Later, based on that assumption, the question of what has driven disability policy changes was posed, with six main factors appearing from the data: (1) political regime transformation and democratic consolidation; (2) international actors' influence and policy transfer; (3) civil society transformation and NGOs' activities; (4) the creation of a new ministry; (5) incoherence and diversity; and (6) political correctness. Those drivers of the changed Croatian disability policy mostly overlap with the factors identified by theory that determine policy change through layering. Six findings arose from the comparison of the empirically derived and theoretical factors.

First, policy actors are crucial features of the change process in both theory and in the empirical example. In Croatian disability policy, official actors (the new ministry) and unofficial actors (NGOs) have both had a significant influence on policy change, and appeared as two separate factors. Then, second, the layering should be marked by the low barriers to authoritative policy change, as was quite evident in Croatian disability policy. The transformation of the political regime and the democratic consolidation stress how the altered partisan balance and new coalition in power opened up a space for big regulatory changes in Croatian disability policy. This is coherent with two theoretical factors: the influence of electoral results and of the institutional decision-making rules on the status quo.

The layering should also be characterised by high barriers to internal policy change. Croatian disability policy has a strong constituency in the form of traditional associations that block attempts to dismantle the old policy elements. This is also consistent with the theory emphasising the influence of vested interests, as the third finding. Fourth, the incoherent and unsystematic implementation of Croatian disability policy is connected to the factor of internal policy structure as a driver of change. This code also stresses significant implemental discretion, but this factor is 'inversely proportional' in theory to what is found in the case study. Low levels of discretion create a

high barrier to internal policy change and enhanced layering, and Croatian disability policy shows high levels of discretion. This should be further examined. Fifth, the change in discourse reflected in the political correctness seen in Croatian disability policy is closely related to ideational factors, which reveals the direction of change towards the human rights disability model.

In the end, the most important finding in the case study of Croatian disability policy is the sixth one, something completely overlooked in the theoretical framework of gradual policy change, namely the influence of policy transfer. Policy transfer could be an important driver of change through the cooperation of national actors with international actors, or by the direct agency of international actors within some national policy, or by setting international standards as a goal of national policymaking. This factor is very important in smaller countries and in countries included in international integrations. Europeanisation is one of those factors holding a great influence. Europeanisation often fosters fast formal/regulatory policy change that is not accompanied by a change in policy implementation. This should be further examined as a factor of policy layering. Moreover, all factors should be operationalised more precisely, in terms of their indicators, direction and potential combinations. It seems to me that four-matrix policy conceptualisations as shown in Table 1 do not satisfactorily fit real-world examples of policy change. I believe that further empirical research and theorising should seek to identify more taxonomical modes of policy changes that actually appear in practice.

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Appendix

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