Policy and Society, 2026, **45(3)**, 358–370
DOI: https://doi.org/10.1093/polsoc/puaf026
Advance Access Publication Date: 23 September 2025
Original Research Article

Modes of involvement: citizen participation in the Norwegian health and planning sector

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Abstract

This study explores the varying patterns and dynamics of citizen engagement across policy fields and participation formats. It zooms in on the Norwegian context and focuses on those two fields where citizen involvement is most pronounced, that is the health sector and the planning field. Based on in-depth empirical analysis, it identifies three distinct modes of public involvement that differ in terms of key actors, influence channels, state–society relations, citizens' roles, and the normative status of their claims. The study finds that the traditional corporatist mode is still prevalent in both health and planning, but complemented by the peer support worker-mode in health, and one-sided information exchange between civil servants and citizens in urban planning. It uncovers the underlying logics shaping the different participation patterns and examines the preconditions and interrelations between social diversity and policy impact in each mode, thereby addressing two of the most persistent shortcomings of citizen engagement. The empirical analysis draws on interviews with civil servants, stakeholders, and researchers, as well as documents like laws, policy guidelines, and committee reports. It builds on existing research on participatory governance, policy development, and knowledge-based policy-making, and it engages with and refines democratic theory with a focus on participation, representation, and inclusion.

Keywords: citizen participation; planning policy; health sector; public involvement; participatory governance; engagement

The ways in which citizens engage in policy-making vary significantly across different contexts. While participation rights are well-developed in social and environmental policy worldwide, they are far rarer in areas like tax or defense, despite the significant impact these domains have on citizens. Although democratic innovations have spread in the last three decades, they coexist with traditional channels, creating a diverse range of access opportunities. This variation makes comparisons both fascinating and challenging, which is why interpretive empirical studies of participation often focus on a single policy field (Alm Andreassen, 2018; Hovik et al., 2024; Meriluoto, 2017; Smith-Merry, 2012) and usually just one participatory format, such as online petitions or advisory councils (Austin & Johannessen, 2015; Sagen et al., 2022; Sandvin Olsson et al., 2023; Smith-Merry, 2012).

This study builds on this work but adopts a broader, comparative perspective to explore the varying patterns and dynamics of citizen engagement. It asks how citizens participate politically across policy fields and formats and conceptualizes different modes of public involvement that vary systematically

regarding key actors, influence channels, participant selection rules, state–society relations, and the normative status of citizens' input. To ensure a focused comparison, the study concentrates on the Norwegian context and on policy fields with high levels of citizen engagement. While citizen participation has become "the new normal" in many sectors of Norwegian society (Juritzen, 2021), it is particularly well-defined in health and spatial planning.[1] In these fields, participation is mandatory in Norway, and special rights are granted to certain groups (youth, the elderly, disabled individuals, Sami people, those with mental health or substance use issues, and caregivers). Comparing fields with high and low citizen participation would certainly also be possible, but the chosen 'most similar' approach offers distinct advantages. Focusing on fields with pronounced activity provides rich data, many observable phenomena, a higher likelihood of identifying best practices to serve as models, and deeper insights into impact dynamics that are of particular interest to this study.

The differentiated participation rights give rise to a diverse range of involvement practices and numerous innovative approaches, while the traditional corporatist model of organizing state–society relations is increasingly under challenge (Allern, 2023; Christensen & Holst, 2020; Knutsen et al., 2023, p. 71; Sivesind & Enroljas, 2022). It will be particularly insightful to determine whether the corporatist model has been replaced or merely supplemented by alternative engagement logics. The study also investigates how to achieve effective and meaningful participation within the different modes of involvement. It thus addresses a common finding in participatory governance research: that influence is often limited and the sample of participants socially biased toward the better-off (Bobbio, 2019; Fung, 2006; Geissel & Michels, 2023, p. 288; Krick 2022; Mansbridge et al., 2012; Schröder & Neumayr, 2023). The study shows which institutional arrangements foster impact, as well as diversity of citizen engagement practices, thereby pointing to the interdependence and tensions between these two qualities and providing differentiated responses to the logics of exclusion at play in the identified modes of public involvement. The study shows how participatory structures and dynamics are connected to broader normative questions. It demonstrates *inter alia* how different logics of access and selection enable distinct modes of achieving representativeness—distinguishing in particular between descriptive representation, which hinges on demographic similarity between representatives and the wider citizenry, and substantive representation, which depends on organizational feedback mechanisms between delegates and their constituencies. The analysis theorizes how the identified modes of involvement, along with their underlying representational logics and their degree of "coupling" with the political system, influence the democratic legitimacy of citizens speaking on behalf of others, the authority and generalizability of their claims, and the extent to which their voices resonate in the policy realm. For these theoretical and normative discussions, it builds on and advances different bodies of theory, most importantly democratic theories of participation and representation (Blumenau et al., 2024; Dean, 2017; Fung, 2006; Hendricks, 2016; Krick 2021, 2022; Mansbridge et al., 2012; Saward, 2010; Setälä, 2017; Young, 2000).

The empirical analysis is grounded in data from 22 interviews and background discussions, conducted in both English and Norwegian, with civil servants, interest group representatives, and researchers, alongside desk research of approximately 200 documents. Documents include laws, legal commentaries, administrative guidelines, committee reports, expert statements, and policy papers. Interviewees were recruited in a targeted way to begin with, with the rationale of covering a variety of different types of actors with different viewpoints. Increasingly, selection snowballed following recommendations by the established network. Interviews roughly followed a guideline that was developed on the grounds of prior research and adapted during the process to accommodate upcoming themes and interests (see Supplementary Appendix). The interviews and key documents were analyzed using thematic analysis. Themes were developed both deductively—guided by the initial research focus and theoretical framework—and inductively, emerging through an iterative process of coding, collecting additional data, and refining the research focus in light of new insights. For example, while the study initially emphasized the impact of citizens' knowledge, this line of inquiry ultimately became a sub-theme within a broader exploration of patterns of involvement. Similarly, considerable effort was devoted to identifying the most participatory policy fields; although this did not become a central theme in the analysis, it served as a crucial foundation for the selection of policy fields as cases. Apart from the collected data, the study also builds on existing qualitative research on collaborative governance, democratic innovations, and organized interests

1 The rights go primarily back to the Health and Care Services Act ("Helse- og omsorgstjenesteloven") and the Patient and User Rights Act ("Pasient og brukerrettighetsloven"), the Local Government Act ("Kommuneloven"), and the Planning and Building Act ("Plan og bygningsloven").

in Norway (e.g., Alm Andreassen, 2018; Baumann et al., 2022; Hagen & Andersen, 2021; Hovik et al., 2024; Legard et al., 2019; Sandvin Olsson et al., 2020, 2023; Sagen et al., 2022).

The study is structured as follows: After highlighting the drivers of citizen engagement, the following section describes for each policy field who gets involved, which participation formats are used, how representative the most influential input channels are, and how they are coupled with the politico-administrative system. Building on this empirical foundation, the subsequent section conceptualizes two novel modes of involvement alongside the still vibrant corporatist mode, each defined by key actors, most influential access channels, and participant selection rules—creating patterns that systematically impact the authority and representativeness of public involvement. The conclusion summarizes the study's key findings, provides tentative explanations for the observed patterns, points at open questions and limitations, and sums up the study's contribution.

Structures of participation: channels of involvement and key players

Local community involvement in urban development and planning in Norway

With increasing land-use conflicts, more ambitious sustainability goals, increased autonomy and revenue for municipalities, and the rising influence of private construction firms, chances of public involvement in Norwegian local planning have continuously been expanded.[2] By strengthening local communities' early involvement rights, public authorities hoped to achieve more common good-oriented decisions and reduce the need for adjusting plans, regulating exceptions, and making case-by-case decisions, thus increasing the legitimacy and predictability of often contested urban planning policies.[3]

In planning, a range of participatory opportunities is necessitated by Norwegian law: Citizens are asked for input when the planning process is announced and before the planning proposal is sent out to hearings, and they have the right to initiate a citizens' proposal.[4] All municipalities must furthermore establish special councils for marginalized groups (youth, the elderly, and disabled individuals), addressing urban development issues, among others. In addition, voluntary participation methods inform citizens or gather their insights on local planning issues. The most common methods include websites, flyers, (social) media, public meetings, and in-person office hours (Opinion AS, 2021; Klausen et al., 2013). Of course, voluntary forms of involvement differ from one municipality to the other. In Oslo, which can serve as an example of an average case of citizen involvement (Hovik et al., 2024), a digital database provides information on all that is planned in the city (often called "Saksinnsyn"). Citizens can address the responsible city council committee proactively with all kinds of requests[5]; they can use one of the numerous digital input channels established on specific planning issues for all kinds of target groups, such as "Gamle Oslo involverer"; and they can use the "walks methodology", i.e., an organized walking tour coordinated with a digital map-app that motivates participants to register, name and rate places, enter notes on their experience with the local environment and take pictures or videos.[6] As a particularly fashionable participation method, lot-based minipublics (often: "Folkepaneler") are now also used on urban development and planning issues, but their numbers are still very small.[7]

Of all involvement channels, the councils of marginalized groups have a particularly good chance of influencing local politics and of amplifying some of the quieter societal voices, thus enhancing overall diversity in policy-making (Proba, 2022). Their members are selected by local governments, sometimes following suggestions from interest groups. Youth councils often include members with backgrounds in pupils' councils ("Elevråd") or youth clubs, while other councils typically feature local politicians and

2 See the Official Norwegian Report (Green Paper) that prepared the reform of the Planning and Building Act (NOU 2003:14. https://www.regjeringen.no/no/dokumenter/nou-2003-14/id382097/?ch=1.

3 See the explanation for a reform of the Planning and Building Act (Ot.prp. nr. 32 (2007-2008), *Om lov om planlegging og byggesaksbehandling*. https://www.regjeringen.no/no/dokumenter/otprp-nr-32-2007-2008-/id500508/.

4 The proposal needs to be backed by 300 citizens, and the city council must deal with it within 6 months. The website www.minsak.no is the gateway to initiate a proposal and to find and sign existing proposals (https://www.regjeringen.no/contentassets/7596a2d77524488d88a32f58a5aeac36/innbyggerforslag.pdf).

5 This directory gives insight into Oslo's ongoing local policy issues (https://www.oslo.kommune.no/politikk/bystyret/slik-kan-du-pavirke-politisk/).

6 The walks-methodology is used by many municipalities in Norway and takes various forms such as children's walks ("Barnetråkk"), people's walks ("Folketråkk"), and senior walks ("Eldretråkk" or "Seniortråkk").

7 Examples in the field of city development are "Folkestemmen" in Larvik, "Ungt folkepanel" in Hillevåg, "Småhusplanen" in Oslo and "Lokalmiljøutvikling" on Romsås, but there are also minipublics debating other policy issues, such as agriculture or climate adaptation (https://socentral.slite.page/p/LQE41gzSf0AqXS/Folkepaneler-vi-jobber-med?backward=), and in September 2024, the first national-level minipublic was established by the Ministry of Digitalisation and Public Governance.

interest group representatives (Proba, 2022). Although these councils engage informally with their target groups, there are no systematic procedures established to link constituents' voices with their representatives. Moreover, the councils do not always fully reflect their constituencies demographically, as Hagen & Andersen (2021, p. 15) underline for the case of youth councils. With local politicians among members and civil servants as observers, the special councils are closely tied to the policy-making sphere, which enhances their chances of being heard (Proba, 2022). They have access to relevant information and can provide input on a wide range of local issues, not just planning matters, where every citizen has the right to comment. The trainings offered to council members further support their ability to fulfill representative roles and assert themselves effectively (Proba, 2022).[8] The high degree of societal self-organization in the field is another important precondition of public impact. While overall participation in interest groups has slightly declined in Norway, involvement in associations that voice local preferences (such as "velforeninger and "grendelag") has been growing, underscoring these organizations' continued influence.[9] Research shows that another highly effective way to influence local policy is through direct, personal contact with politicians via face-to-face meetings, phone calls, social media, and email (Legard & Hovik, 2022; Klausen et al., 2013; Sivesind & Enroljas, 2022). This is especially true for narrow, concrete issues with little financial implications, like town square development (Hovik et al., 2024; Proba, 2022). Chances to impact policy processes through these direct contact channels are evidently not evenly distributed, however, with young women with a migrant background among the most marginalized (Andersen & Lorenzen, 2021, p. 229).

Many scholars point out that the impact of citizens and local associations on urban planning and development is generally more advisory than substantive and authoritative, and the state–society relationship is often not so much about dialog but about information exchange (Andersen & Lorenzen, 2021; Knudtzon, 2018; Klausen et al., 2013). Local public authorities receive public input but are not obliged to engage with it, and they reserve the right to take the final political decisions (Hovik et al., 2024, p. 6; Knudtzon, 2018). What is more, planning and building in Norway is in the hands of private firms, whose efforts at public involvement rarely go beyond the bare minimum required (Hagen & Andersen, 2021; Klausen et al., 2013). Yet, even though citizens' final decision-making power may be limited, citizen engagement often makes an important difference in local politics (Hovik et al., 2024).

Patient involvement in the Norwegian health sector

Grounded in human rights and the principle of equal access to societal resources, Norway has transferred considerable power to patients—fostering more communicative, egalitarian doctor–patient relationships and expanding opportunities for participation. These developments reflect a broader transformation in health care, influenced by a range of factors, including the move from paternalism to patient empowerment, psychotherapy's emphasis on dialogue, growing attention to medical ethics following research scandals, and the rising prevalence of chronic conditions like obesity, depression, and substance abuse, which demand greater patient involvement (Nylenna, 2020).[10]

Citizens chiefly get involved in health policy and service development through "user organisations," which are usually (co-)funded by the state. In addition to the "Norwegian Patient Association" and the "Patient and User Representation" that bring in general patients' interests, there are numerous, more specialized organizations representing those affected by certain illnesses or patients' caretakers, such as the Norwegian Cancer Society or the Caregiver Alliance. An extraordinary user organization is "Erfaringssentrum" (literal translation: experience center), which is the professional association of 'peer support workers' who are employed by health institutions to support those with similar experiences ("peers"), organize user involvement and feed experience-based expertise into the system (Austin & Johannessen, 2015; Alm Andreassen, 2018).[11] Many countries, including Norway, have now established training courses that help experts-by-experience to reflect upon and harness their personal experience with an illness,

8 These trainings comprise the "Folkevalgopplæring"-program by KS, the "Kompetanseprogram for folkevalgte" by Norsk kommunalteknisk forening (NKF), as well as courses offered by the respective interest groups.

9 See NOU 2011/14; https://www.regjeringen.no/no/dokumenter/nou-2011-14/id647388/?ch=11).

10 In the health sector, a distinction is often made between macro-, meso-, and micro-level public involvement. Because of their political dimension, only the macro- and meso-levels of health policy legislation and implementation are of interest to this study. Micro-level participation relates to involving individual patients in their own health decisions.

11 In the English-speaking context, where this model originated, "erfaringskonsulenter" are called, inter alia, "lived experience practitioners," "peer counsellors," "experts-by-experience," "peer support workers," and "peer-providers", as well as "consumer consultants," "consumer-providers," and "consumer employees."

its treatment, and the health system.[12] The idea of mobilizing experience-based knowledge is pushed for by these schools, by peer support workers' professional organization, as well as by several publicly funded hybrids of advocacy organization and knowledge broker that are engaged in developing, systematizing, and disseminating experiential knowledge and advocating user voices.[13]

The directorate of health links up with civic organizations through two national-level "user councils."[14] For every assignment it receives, the directorate furthermore establishes specialized working groups, including at least two service user representatives alongside other experts (usually clinical and scientific). While the directorate emphasizes institutional ties with organized groups and prioritizes their aggregated knowledge, it also seeks to include individual perspectives from non-organized citizens through participatory methods like 'world cafes'. There are a range of additional institutions linking patient representatives with the health system at the local level. In addition to the aforementioned special councils for the elderly and disabled, which are sometimes involved in health and care matters, notable examples include "Healthy Life and Coping Centers" within the primary care system (Sandvin Olsson et al., 2023) and "Patient Advisory Boards" established in rehabilitation institutions (Sagen et al., 2022).

When selecting user representatives for these arenas, health institutions aim to retain control over the process. The health directorate, for instance, notes suggestions by organized groups but sends out invitations to a range of individuals and chooses two to three persons after an interviewing process. In general, candidates are preferred who can speak for their group from a broader, "meta" perspective rather than focusing heavily on personal experience (Alm Andreassen, 2018; Sandvin Olsson et al., 2023). Interest organizations gain political traction when they are elected or appointed to public health councils and committees, when they are invited to contribute to legislative hearings, or when they present regular reports to the parliamentary health committee.[15] Proactively, they use (social) media to promote their agendas, address politicians and other authorities directly with their key issues, deliver public speeches to highlight areas needing improvement, and commission research to push key issues onto the political agenda. These channels generally offer meaningful opportunities for user organizations to shape health policy and services. Yet, the involvement of patients does not necessarily amount to co-deciding on policies or organizational change. It is often of a rather advisory nature and its effect is not always directly obvious. User representatives on Patient Advisory Boards, for example, frequently describe their influence as limited (Sagen et al., 2022).

A key condition for impact is being organized as a group that is both recognized as a legitimate representative of affected users and institutionally connected to the political system. Early involvement and strong commitment from decision-makers are also crucial. In more demanding deliberative forums—particularly those involving multiple stakeholders—effective participation further depends on open dialogue, skilled facilitation, sufficient time for negotiation, and feedback mechanisms to monitor how patients' perspectives are incorporated into decisions (Baumann et al., 2022). Studies on patient involvement furthermore highlight the importance of encoding and respecting users' input, which is often undervalued by healthcare personnel (Sagen et al., 2022; Sandvin Olsson et al., 2023; Smith-Merry, 2012).

Modes of citizen involvement

Both societal sectors under consideration are defined by distinct modes of involvement that differ systematically regarding the interplay of key institutions and actors. The modes' characteristic patterns of participation regarding the involved actors, the selection rules, and the accessed participation channels have significant implications for central questions in policy-making and, more specifically, in participatory governance. These include the balance and diversity of voices involved, the logic of representation underlying participatory practices, the role of the state relative to civil society, the status of citizens' claims,

12 "Erfaringsskolen" in Oslo, "KBT Fagskolen" in Trondheim, and the "MB-Programme" in Bergen are the three institutions that offer training for peer support workers in Norway; see https://erfaringssentrum.no/erfaringskonsulenter-og-opplaering/.

13 Important examples are the 'National Center for Experience-Based Knowledge', the 'Competence Center for Lived Experience and Service Development' and the 'Norwegian Resource Center for Community Mental Health'; see https://erfaringskompetanse.no/kontakt-oss/, https://kbtkompetanse.no/om-kbt/and https://napha.no/content/25371/about-napha.

14 In the general council ("Brukerråd") that consists of currently 20 interest organizations (such as the "Autism Association" or the "Pensioners Association"), the directorate of health is represented with several members, including the directorate's general leadership and the leader of the directorate's internal unit dedicated to user involvement ("Center for User Involvement"). The other national level user council ("BrukerRoP") focuses on mental health- and drug-related issues and consists currently of 23 user organizations, such as the "Eating Disorder Association" or the "Children of Drug Addicts."

15 Hearings are usually public so everyone can come with input, but a (public) list of organizations is explicitly invited to send comments.

and their potential to influence policy decisions. For example, whether participation is driven by individuals or organized groups, and whether access is open, invitation-based, or employment-related, can determine how well the input reflects the interests of all those affected, the reliability and value of citizens' claims, the accessibility of engagement opportunities, and how effectively the participatory process is integrated into policy-making.

For each sector or policy field, two dominant modes can be identified, with one of these modes—that is, the mode of "organized-democracy"—playing a key role in both fields.

Mode 1: the corporatist mode of organized democracy

In the "organized democracy" (Olsen, 1983) or corporatist involvement mode, citizens are involved through "user" organizations. The mode builds on a high degree of societal organization and close, neo-corporatist state–civil society relations. The mode is still typical for the Nordic countries (Alm Andreassen, 2018; Allern, 2023; Nylenna, 2020) where it widely translates into political institutions and practices of decision-making, and it characterizes both the health and the planning sector in Norway. Its origins trace back several centuries, with an "associative spirit" taking hold as early as the 1830s in Norway. The emergence of organized interests gained momentum in the late 19th century, followed by increasing specialization in the 20th century (Allern, 2023; Nylenna, 2020). Today, organized groups are often regarded as "pioneers," having laid the groundwork for what would later become fundamental functions of the welfare system.[16]

The mode's logic of representation builds on accountability relationships between representatives and their constituency (i.e., the members of organized groups), whereby spokespersons are authorized to speak for the group they represent and held to account for it. Typical influence channels in this mode are councils of representatives and hearings convened by the public administration to involve spokespersons of affected groups (see Table 1). The close embedding of these access channels into the structure of the political system comes with relatively high chances of impact, and the fact that policy-makers actively seek the aggregated input of specialized interest groups for the insight it provides reconfirms its status.

If there were a balance of power in the world of organized interests, the corporatist mode would in many ways be the ideal mode of involvement. However, this is not the case. Groups with more resources are much better equipped to form powerful pressure groups. Across policy sectors in Norway, although access to hearings and "input conferences" is relatively open to smaller, less-resourced groups, only a limited number of "insiders" maintain regular, direct, and close contact with policymakers (Sivesind & Enroljas, 2022, p. 82). Therefore, the Norwegian state, as many European countries and the EU, supports less privileged groups through measures like reserved seats, quotas, public funding for self-organization, and special councils representing marginalized communities (Krick 2021, pp. 148ff.). Such affirmative

Table 1. Modes of involvement.

	The corporatist mode of organized democracy (health and planning)	Information and consultation (urban planning)	Peer support worker mode (health)
Main actors	Organized stakeholders	Individuals living or working in the locality	Individual 'experts-by experience'
Most influential participation channels	Councils of representatives and hearings	Constituents' queries, petitions, complaints, and use of input platforms	Employment by health institutions
Logic of access and participant selection	Usually invited targeted recruitment	Open self-selection	Professional Competitive recruitment
Representative status of claims	Substantive representation of the group's views	Self-representation (speaking for oneself)	Ambiguous
Main normative challenge	Balance of interests	Descriptive representation of all those affected	Procedures for processing and integrating different viewpoints

Note. Table compiled by the author (own elaboration).

16 See the Government White Paper St.meld. nr. 39 (2006–2007), https://www.regjeringen.no/no/dokumenter/Stmeld-nr-39-2007-/id477331/.

action ensures more equal access for those affected, helping authorities gain a more comprehensive understanding of all affected viewpoints.

The corporatist mode of involvement and the underlying substantive, affirmative action-enhanced idea of representation align with the targeted recruitment selection rule. Under this rule, those with substantive authority to make representative claims for an affected group are granted access to policy-preparing forums by public authorities. In contrast, unmediated participation on open (e-)platforms is less compatible with this logic of representation (Legard et al., 2019). In the organized democracy mode, civic organizations become both carriers of interests and, at the same time, providers of knowledge that is used by those in charge of health service deliverables (Alm Andreassen, 2018; Krick 2015). For both epistemic reliability and democratic representativeness, citizens' views must be aggregated and processed (Krick 2022). User organizations perform this role by presenting collective perspectives and speaking on behalf of their groups, gaining recognition from authorities who invite them to hearings and other policymaking channels. To support this, user organizations and state authorities provide training on "how to be a good representative" (i.e., speak for others). Particularly valuable from an epistemic standpoint are the less-heard voices, expressed by migrant or youth associations, for instance, as they offer fresh insights for policy development.

Mode 2: employing experts-by-experience in health institutions

An up-and-coming mode of involvement that differs from the corporatist mode is about health institutions *employing service users as peer support workers* (see also Alm Andreassen, 2018; Meriluoto, 2017; Ose & Kaspersen, 2023).[17] Peer support workers are explicitly hired for their qualifications and skills as "experts-by-experience" by health agencies or hospitals (Alm Andreassen, 2018, p. 109). Their incorporation into the health organization sends a clear signal that their input is seen as a useful contribution and their salary a worthwhile investment. It validates their experiences and provides good conditions for impacting health services from within. That the knowledge of peer support workers is not "everyday knowledge," but quite specialized, comparably inaccessible knowledge that builds on relatively rare, firsthand, lived experiences further adds to the value of their claims. Yet, impact chances also likely vary with the generalizability of claims, and the status of (employed) service users' claims is in fact a bit ambiguous. They are usually not seen as representatives of user organizations, or as "ordinary," "typical" citizens speaking for themselves, but as "individuals personifying a 'generalized service user'" (Alm Andreassen, 2018, p. 108; see also Alm Andreassen, 2015). Instead of "just talking about oneself," the claims of peer support workers are often expected to be "analysed," meaning that personal, emotional stories need to be transformed into a coherent, neutral and "abstract" story (Meriluoto, 2018, p. 128). Yet, even though employed experts-by-experience are usually expected to speak for those with similar problems, and convey "typical viewpoints of those affected" (Alm Andreassen, 2018, p. 109), it is usually not institutionalized or transparent how this should be done. What is more, demands toward peer support workers are often contradictory, since they are also regularly asked to tell "strong stories" based on their own tales of suffering (Mohn-Haug, 2021). The expanding availability of trainings for peer support workers in many countries offers a pathway from the role of a personally affected individual to that of an expert-by-experience with a broader overview of peer perspectives. This transformation enables the provision of "analyzed" and generalizable knowledge, detached from personal narratives, that reflects diverse perspectives and is more likely to influence public discourse and policy discussions (Meriluoto, 2017, p. 10). Yet, as the Norwegian empirics underline, first, not all training courses pursue that aim, and second, a certificate is usually not mandatory for being employed. Furthermore, on a different note, training programs that streamline the stories of individuals with profoundly challenging life experiences have been rightly criticized as "normalisation" strategies that dilute the authenticity of their knowledge (Meriluoto, 2017). Besides, there is a certain risk that peer support workers might be seen as "inauthentic" if they are perceived as too professional or informed (Martin, 2008).

When there are no feedback procedures in place, whereby peer support workers, like interest group spokespersons, pool the views of those they stand for, and are selected and sanctioned by their constituency, individual peer support workers cannot fulfill the criteria of accountability-based, substantive

17 The advent of the profession is reflected by a growing number of peer support workers employed in public institutions, the rising state funding for its professional association, and the steady growth in both its membership and staffing levels (Interviews; Ose & Kaspersen, 2023).

representativeness. Neither can a single person be statistically or descriptively representative of a larger collective under conditions of plurality. While a person with experiential knowledge about illness and treatment can bring an important perspective into the health system that complements professional views in a valuable way, claiming that this view is particularly representative of other patients and should be generalized on these grounds can easily be contested with reference to the variety of patients' life situations and experiences. Indeed, there are various other foundations on which individuals base representative claims, including skills, a shared history of action, policy responsiveness to public opinion, or dedication to a common cause (Martin, 2008; Saward, 2010). Yet, the "selection-based modes" (Blumenau et al., 2024) of descriptive or substantive representation offer the significant advantage of enabling us to assess the generalizability and multi-perspectivity of these claims, which in turn influences their democratic legitimacy and epistemic value.

To understand why the peer support worker mode has become particularly prominent in the health sector, it is important to recognize that peer support workers usually represent a specific subgroup of patients, namely people who have experienced and recovered from mental health problems and/or substance abuse. That a special involvement mode developed for this subgroup has to do with a long history of discrimination against these types of illness. Patients with these experiences were not taken seriously and stigmatized for a long time within the hierarchy of illnesses, which called for affirmative action and an amplification of these voices (Bjørgen, 2013). Another reason for elevating these experiences specifically may be that "less biological" health problems demand forms of knowledge and responses beyond the purview of medical professionals. Besides, the steep increase in mental health issues during the last decades highlighted these issues and called for their recognition. Finally, the employment of individuals with these experiences can be read as an antidote to the closed nature of the corporatist model.

Mode 3: informational and consultative involvement in urban planning

Especially in the planning field, another mode of citizen involvement and influence is widespread (alongside the corporatist mode) that is at its core about (often one-sided) *information and consultation*. In this mode, citizens are informed by public authorities or consulted as knowledge sources and asked about their needs. Those getting involved are the affected parties of the local community, that is residents, neighborhood associations, local businesses, and politicians (NIBR, 2013, p. 27), who are motivated to participate because they use and know the locality, and therefore benefit from improvements. This mode is not so much about negotiation between civil society and political decision-makers. Rather, information often flows into one direction only through channels such as petitioning letters to MPs, online input platforms or public announcements, but there are also a range of more interactive, conversational channels of information exchange in use in the field, such as local "surgeries" (i.e., regular meeting sessions of MPs with their constituencies), drop-by-office-days and town hall meetings.[18]

Channels of involvement in this mode typically follow an open-access logic. This aspect clearly differs from the two formerly described modes, and it has consequences for the bases of representative claims and the specific mechanisms of exclusion and inclusion at play. The fact that access is formally unrestricted and that the resources of time, qualification, rhetorical skill, and experience required for information exchange are limited compared to deliberative or corporatist forms of involvement, in theory, means low entry barriers and openness toward all kinds of input. Yet, it will often be very experienced individual activists and "super-participants" as well as organized groups such as neighborhood associations that get engaged (Hovik et al., 2022). To the latter types of actors, similar challenges as in the corporatist mode apply from a perspective of inclusion and representation. From nonorganized individuals participating in these forums, all that can be expected is "self-representation," i.e., speaking for and representing one's own interest (Saward, 2010, p. 101). Of course, calling this "representation" at all stretches the concept quite far. In any case, claims made by an individual participating through an open-access platform cannot be generalized because that person does not have the authority to speak for a collective and would usually also refuse to do that. Naturally, if many individuals speak for themselves, it is theoretically possible that they, as a whole, mirror the population, thus fulfilling the similarity conditions of descriptive representation. But it cannot be assumed as given. In fact, when access to participatory channels is open, logics of self-selection apply. This usually means that the selection of those participating is particularly distorted

18 While one-sided informational flow also exists in the health sector, it is especially developed and formalized in planning processes, with the mandatory publication of plans and numerous online platforms for public input on local infrastructure issues, for example.

toward the privileged voices in society, that is affluent, better-educated men over 50 years and established interest groups with resources (Krick 2021, p. 138; Hovik et al., 2024, p. 5; Legard & Hovik, 2022, p. 9). To these privileged social groups, the use of the particularly influential participation channel of directly contacting politicians with queries, petitions, and complaints will come most naturally, while socially disadvantaged groups and children, by contrast, rarely engage in this way. Yet, their perspectives are of particular epistemic value precisely because they are least heard and particularly far removed from typically well-educated, affluent planners and civil servants. It lies largely in the hands of public authorities to compensate for privilege and ensure a comprehensive representation of the community's concerns by filtering the received input and actively seeking the views of the less privileged. To encourage the involvement of marginalized groups, special initiatives can be employed, such as sending out paid ambassadors from migrant backgrounds to motivate peers (Legard & Hovik, 2022, p. 178).

As in the case of the peer support worker mode, it seems likely that the informational mode developed partly in response to specific needs in the fields and to societal demands that are not met by the corporatist mode. The mode of informational exchange seems well suited to some recent trends in political participation, such as the growing focus on single issues and the reluctance toward long-term commitment in political organizations. The rather low-threshold and low-maintenance nature of the information exchange mode with its self-selection logic also aligns with the nature of participation rights on local issues in Norway, which are extensive but relatively basic. They go back to the early days of the "participatory turn" when citizen engagement was less deliberative than about being informed and, at best, consulted.

Conclusion

A key finding of this study is that the corporatist model of organized democracy, with its strong ties between privileged stakeholders and the state, remains firmly in place in both fields. Contrary to the widespread belief that corporatism is fading—even in the Nordic countries—it is very much alive in Norway. With deep cultural roots, this model is embedded in and required by Norway's political system. As a consensus-driven democracy, Norway relies on broad participation and institutions that foster agreement. Institutionalized involvement of key stakeholders is a central mechanism for achieving this. Across various policy fields, the organized democracy model is widely embraced, and Norway ranks highly for involving organizations (not individuals) in decision-making (Knutsen et al., 2023). Their input can, with good reason, be considered substantively representative of the citizenry's views and thus assume considerable authority in the policy realm.

A *second* key finding is that the corporatist model has recently been supplemented by alternative modes of participation that address public calls for a more direct involvement of individuals in policymaking. In the health sector, a mode has emerged that amplifies the voices of marginalized mental health patients, while in urban development, numerous mechanisms now facilitate information exchange between local citizens and policymakers. These alternative modes do not replace corporatism but exist alongside it, in parts addressing its weaknesses and responding to societal shifts, such as the rise of individualized, single-issue engagement in participatory processes. The consolidation of the two alternative modes in these two domains may furthermore reflect a growing significance of public participation as a mechanism of "knowledge transfer", alongside the more common purposes of empowerment and democratization (Dean, 2017, p. 218f.; see also Meriluoto, 2018, p. 127f.; cf. Bobbio, 2019). Many health and planning issues fall within what Goffman (1971, 38) calls the "information preserve" of individuals. With privileged access to knowledge about their bodies, their life stories and environments, even 'ordinary' citizens can make meaningful contributions to improving public services and developing effective policy solutions—rendering public involvement in these areas compelling for epistemic, as well as democratic reasons. To be sure, organized stakeholders also hold important expertise, but the rationale for involvement in the corporatist mode is usually more evidently one of political negotiation between competing interests and less about retrieving information.

Third, notably, the idea that randomly selected minipublics are better at representing the general population has not caught on in Norway, unlike in countries such as Germany and the UK. In Norway, lot-based participatory formats are only beginning to be tested in planning, while they are virtually absent in health. This is unlikely to be due to the choice of policy fields in this study, as the UK, with a similarly organized public health system, extensively uses lot-based methods in the health field, and Germany, with comparable local autonomy, quite intensely applies minipublics in local development.

A fourth key finding is that, aside from direct lobbying, the most significant factor for impact across modes is the institutional integration of citizen involvement channels into public institutions via seats for affected individuals in advisory councils or user employment in public agencies. While the link between institutional "coupling" and policy impact is well-established in participatory research, the empirical analysis highlights cases where this connection works effectively. This is particularly the case when the institutions are *loosely coupled*, maintaining constant feedback loops and transmission mechanisms between the participatory arena and decision-making body without interfering with each other's operations (Hendricks, 2016; Krick 2021; Mansbridge et al., 2012; Setälä, 2017). The institutionalised involvement channels enhance access for certain marginalized groups (i.e., those that have been granted special rights) in both fields. In health, this refers to individuals with mental health or substance abuse issues, while in planning, it pertains to older, disabled, and young people. The institutional conditions for counteracting the two weakest points of participatory governance (effectiveness and diversity) are thus interconnected at this point: when participation opportunities are well coupled with the political system, "weaker" voices stand a better chance of being heard.

Fifth, the study highlights how a seemingly minor design issue, such as participant selection rules, severely affects the democratic qualities of participation, including the authority and representativeness of citizens' claims. The organized democracy model excels in this respect, since it relies on the targeted recruitment of membership organizations that pool and process their constituency's views into a collective demand. This logic ensures substantive representation of affected viewpoints and a rather high generalizability of claims, increasing the legitimacy of participation and the likelihood of resonance in the policy realm. In contrast, participants in the informational mode are individuals who speak for no larger constituency, but simply for themselves. Peer support workers, recruited in employment selection processes, make claims based on skills, experience, and a shared cause, though it is often unclear how they aggregate their peers' views or navigate the complex demand to speak for others while sharing personal stories.

Sixth, the study underlines that logics of exclusion and partiality affect all modes of involvement, but they play out in different ways and demand targeted interventions. Open-access forums are often dominated by individuals with privilege and political experience. In the organized democracy model, established interest groups with resources are better positioned to influence decision-making, while peer support workers gain credibility in the policy realm when they speak unemotionally, detached, and on a par with professionals and policymakers. In all three cases, equal access can be improved by tailored institutional measures: For non-organized, detached individuals, descriptive representation is key, and lot-based selections or direct outreach to typically sidelined groups can help gather a more complete set of affected perspectives. For peer support workers, establishing procedures to reflect the multiplicity of viewpoints is crucial. This can be done by making the engagement with peer experiences a core element of training courses or by strengthening feedback mechanisms between employed peer support workers and their advocacy organizations (e.g., Norway's "Erfaringssentrum" or the various hybrids of knowledge brokers and pressure groups). To ensure a better balance in the realm of organized interests, the state can support weaker interests by funding self-organization and inviting diverse stakeholders to policy forums, ideally involving the public into the selection process to address biases and blind spots.

Two important questions emerge directly from the cross-sectoral analysis—both highly relevant for explaining the observed patterns, yet beyond the scope of this study to explore in depth. First, why are participation rights particularly prominent in Norway's urban planning and health sectors, while other areas remain less developed in this regard, despite a broader societal trend of "participatory enthusiasm"? What drives citizen engagement specifically in these two domains? Second, how did the informational mode in the planning sector and the peer support worker model in the health sector come to develop? What *sector-specific* factors have shaped these distinct forms of participation? The summarizing account of the origins of participation rights in the study's first sections, along with the reflections concluding the descriptions of emerging participation modes offer initial insights into these questions that could be more thoroughly investigated in future research.

This study certainly has several limitations. Most obviously, the focus on two, quite specific policy fields in Norway and the qualitative approach restrict the generalizability of the findings in some respects. However, the in-depth, comparative analysis provides valuable insights into underlying social mechanisms, offering theoretical relevance beyond the single case. The identification of distinct modes of involvement provides a clearer understanding of how things cohere and which outcomes specific participation patterns can produce, highlighting the conditions that foster desired results. Second, the chosen

focus on cases with strong participation rights spotlights potential models for future approaches. Third, while the empirical study is indeed limited to Norway, its findings are likely relevant to other contexts, particularly similarly generalized, decentralized health systems (e.g., other Nordic countries), regions with strong local self-rule (such as Germany, Switzerland, Finland, or Sweden), and other consensus democracies (particularly the German-speaking and Nordic countries). One might argue that the initial descriptions of local politics and the health sector offer limited theoretical value. However, the empirical data provide a vital foundation for theory development and yield nuanced insights across distinct policy fields. Moreover, the study moves well beyond description by constructing modes of involvement and critically engaging with the normative dimensions of the observed participation patterns.

Funding

This research was funded by the Norwegian Research Council (project no. 336050) and the German Research Council (project no. 523307427).

Conflict of interest

None declared.

References

Allern, E. H. (2023). Mellom korporatisme og lobbyisme. Norske interesseorganisasjoners tilgang til politiske beslutningsprosesser, *Norsk sosiologisk tidskrift*, *7*(4–5), 26–44.

Alm Andreassen, T. (2018). From democratic consultation to user-employment: Shifting institutional embedding of citizen involvement in health and social care. *Journal of Social Policy*, *47*(1), 99–117.

Alm Andreassen, T. (2015). Reforming social services: The institutional and organisational context of the HUSK Program. *Journal of Evidence-Informed Social Work*, *12*(1), 32–49.

Andersen, B. & Lorenzen, S. B. (2021). Ballens uforutsigbare vei mot mål: Medvirkning som matspill. In A. L. Hagen & B. Andersen (Eds.), *Ung medvirkning: Kreativitet og konflikt i planlegging* (pp. 223–246). Cappelen Damm Akademisk.

Antonsen, E. B. (2008). Utbytte av kurs i brukermedvirkning?*Tidsskrift for psykisk helsearbeid*, 5(1), 14–23.

Austin, M. & Johannessen, A. (2015). Enhancing the quality of public social services through the involvement of users: The Norwegian HUSK projects. *Journal of Evidence-Informed Social Work*, *12*(1), 1–6.

Baumann, L. A., Reinhold, A. K., & Brütt, A. L. (2022). Public and patient involvement in health policy decision-making on the health system level—A scoping review. *Health Policy*, *126*(10), 1023–1038.

Bjørgen, D. (2013). Fremveksten av brukermedvirkning i Norge: Strategier og tiltak for å styrke brukeres erfaringskunnskap i teori og praksis. *Tidsskrift for psykisk helsearbeid*, *10 E*(04), 372–378

Blumenau, J., Wolkenstein, F., & Wratil, C. (2024). Citizens' preferences for multidimensional participation. *Perspectives on Politics*, *23*(2), 588–610.

Bobbio, L. (2019). Designing effective public participation. *Policy and Society*, *38*(1), 41–57.

Christensen, J. & Holst, C. (2020). *Ekspertenes inntog*. Universitetsforlaget

Dean, R. J. (2017). Beyond radicalism and resignation: The competing logics for public participation in policy decisions. *Policy & Politics*, *45*(2), 213–230.

Fung, A. (2006). Varieties of participation in complex governance. *Public Administration Review*, *66*(1), 66–75.

Geissel, B. & Michels, A. (2023). Conclusion. Democratic innovations and impact: Reflections and an agenda for the future. In J. Vincent, R. Matthew, & v.d.D. Ramon (Eds.), *The power of democratic innovations—The impact of participatory and deliberative institutions* (p. 288). ECPR Press.

Goffman, E. (1971). *Relations in public: Microstudies of the public order*. Allen Lane The Penguin Press.

Hagen, A. L. & Andersen, B. (2021). Introduksjon til ung medvirkning, kreativitet og konflikt i planlegging. In A. L. Hagen & B. Andersen (Eds.), *Ung medvirkning: Kreativitet og konflikt i planlegging* (pp. 11–41). Cappelen Damm Akademisk.

Hendricks, C. M. (2016). Coupling citizens and elites in deliberative systems: The role of institutional design. *European Journal of Political Research*, 55(1), 43–60.

Hovik, S., Legard, S., McShane, I., Middha, B., Reichborn-Kjennerud, K., & Ruano, J. M. (2022). Participation and influence in urban development: Does city e-participation strategy matter?. In S. Hovik, G. A. Giannoumis,

K. Reichborn-Kjennerud, J. M. Ruano, I. McShane, & S. Legard (Eds.), *Citizen participation in the information society* (pp. 25–48). Palgrave Macmillan.

Hovik, S., Legard, S., & Bertelsen, I. M. (2024). Area-based initiatives and urban democracy. *Cities*, 144 (Jan.), 1–8.

Juritzen, T. (2021). Erfaringskompetanse – 'å bruke en bruker'. Utfordringer i kunnskapsutvikling og praksis. In E. Skjedal (Ed.), *Kritiske perspektiver på brukermedvirkning* (pp. 49–62). Universitetsforlaget.

Klausen, J. E., Arnesen, S., Christensen, D. A., Folkestad, B., Sandkjær Hanssen, G., Winsvold, M., & Aars, J. (2013). *Medvirkning med virkning? NIBR & Uni Rokkansenteret*. https://oda.oslomet.no/oda-xmlui/bitstream/handle/20.500.12199/5459/Samarbeidsrapport-NIBR-UniRokkansenteret-2013-web.pdf?sequence=1&isAllowed=y. Date accessed August 26, 2025.

Knudtzon, L. C. (2018). Democratic theories and potential for influence for civil society in spatial planning processes. In S. Egoz, K. Jørgensen, & D. Ruggeri (Eds.), *Defining landscape democracy: A path to spatial justice* (pp. 3–15). Edward Elgar Publishing.

Knutsen, C. H., Sirianne, D., Elin Haugsgjerd, A., Sara Bjønness, H., Jan Erling, K., & og Tore Wig, M. S. (2023). *Tilstandsanalyse av det norske demokratiet*. Rapport publisert. 17 August 2023. https://www.regjeringen.no/contentassets/b242728c615c40f3a720a56acd56971a/tinde_2023_rapport_endelig_versjon.pdf. Date accessed August 26, 2025.

Krick, E. (2015). Negotiated expertise in policy-making. How governments use hybrid advisory committees, *Science and Public Policy*, 42(4), 487–500.

Krick, E. (2021). Expertise and Participation: Institutional Designs for Policy-Development in Europe. Basingstoke: Palgrave Macmillan.

Krick, E. (2022). Citizen experts in participatory governance. Democratic and epistemic assets of service user involvement, local knowledge and citizen science, *Current Sociology*, *70*(7), 994–1012.

Ladner, A., Keuffer, N., & Bastianen, A. (2023). *Local autonomy around the world: the updated and extended Local Autonomy Index (LAI 2.0)*. Regional and Federal Studies, 35(3), 163–185.

Legard S., Hovik, & S. (2022). The impact of digital participation on democratic urban governance. In S. Hovik, G. A. Giannoumis, K. Reichborn-Kjennerud, J. M. Ruano, I. McShane, & S. Legard (Eds.), *Citizen participation in the information society. Comparing participatory channels in urban development* (pp. 167–189). Palgrave Macmillan.

Legard, S., Hovik, S., & Paupini, C. (2019). Variation in e-participation schemes and strategies: Comparative case study of Oslo, Madrid, and Melbourne. ICEGOV2019, 3–5 April 2019.

Mansbridge, J., Bohman, J., Chambers, S., Christiano, T., Fung, A., Parlinson, J., Thompson, D. F., & Marren, M. E. (2012). A systematic approach to deliberative democracy. In J. Parkinson & J. Mansbridge (Eds.), *Deliberative systems: Deliberative democracy at the large scale* (pp. 1–26). Cambridge University Press.

Martin, G. (2008). 'Ordinary people only': Knowledge, representativeness, and the publics of public participation in healthcare. *Sociology of Health and Illness*, 30(1), 35–54.

Meriluoto, T. (2017). Turning experience into expertise: Technologies of the self in Finnish participatory social policy. *Critical Policy Studies*, *12*(3), 294–313.

Meriluoto, T. (2018). Neutral experts or passionate participants? Renegotiating expertise and the right to act in Finnish participatory social policy. *European Journal of Cultural and Political Sociology*, 5(1-2), 116–139.

Mohn-Haug, T. (2021). *Bekymret for ukritisk bruk av egenerfaringer*. Interview. https://erfaringskompetanse.no/nyheter/bekymret-for-ukritisk-bruk-av-egenerfaringer/?srsltid=AfmBOorwp0FjqWi-g4Ta4Z7kETRdWaI0d0Mbbfsax2t-BLgHNhGjFZHkR

Olsen, J. P. (1983). *Organized democracy, political institutions in a welfare state–The case of Norway*. Universitetsforlaget.

Opinion AS. (2021). *Folketråkk*. Report for DOGA. https://doga.no/globalassets/dokumenter/folketrakk/redigert-rapport_-doga-folketrakk_analyse-2021_rapport_opinion.pdf. Date accessed August 26, 2025.

Ose, S. O. & Kaspersen, S. L. (2023). *Kommunalt psykisk helse- og rusarbeid 2023: Årsverk, kompetanse, og innhold i tjenestene*. Sintef Rapport. https://www.sintef.no/contentassets/b9b01949aa5a4656ad0658151c151ec8/endeligrapport2023.pdf

Proba. (2022). *Erfaringer med lovpålagte råd for medvirkning*. Study conducted for KS by Proba samfunnsanalyse. https://www.ks.no/contentassets/26def46810e84efb85b29b4dcae192a2/Erfaringer-med-rad-for-medvirkning.pdf. Date accessed August 26, 2025.

Sagen, J., Børøsund, E., Simonsen, A. E., Habberstad, A., Kjeken, I., Dagfinrud, H., Moe, R. H. (2022). Organisation, influence, and impact of patient advisory boards in rehabilitation institutions—An explorative cross-sectional study. *BMC Musculoskelet Disord*, *23*(1), 738.

Sandvin Olsson A. B., Stenberg, U., Haaland-Øverby, M., Slettebø, T., & Strøm, A. (2023). Enabling primary healthcare service development with patient participation: A qualitative study of the internal facilitator role in Norway. *Primary Health Care Research & Development*, *24*(57), 1–11.

Saward, M. (2010). *The representative claim*. Oxford University Press.

Schröder, J. M. & Neumayr, M. (2023). How socio-economic inequality affects individuals' civic engagement: A systematic literature review of empirical findings and theoretical explanations. *Socio-Economic Review*, *21*(1), 665–694.

Setälä, M. (2017). Connecting deliberative mini-publics to representative decision making. *European Journal of Political Research*, *56*(4), 846–863.

Sivesind, K. H. & Enroljas, B. (2022). Konklusjon. In K. H. Sivesind & B. Enroljas (Eds.), *Frivillige organisasjoners sivilsamfunnsrolle: påvirkningsstrategier og tilgang til politiske beslutningsfora (ISF report) (pp. 81–86)*.

Smith-Merry, J. (2012). Experiential knowledge in action: Consulting practitioners for policy change. *Policy and Society*, *31*(2), 131–143.

Young, I. M. (2000). *Inclusion and democracy*. Oxford University Press.

 Policy and Society 2026 45(3) 358–370
https://doi.org/10.1093/polsoc/puaf026