

## What Does a Community Pharmacy Owe Its Neighbourhood When Other Health Services Withdraw? Balancing Community Claims, Service Obligations, and Workforce Protection

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### Abstract

Community pharmacies frequently remain visible and accessible when other local health services contract, relocate, become harder to reach, or disappear. Their continuing presence can intensify neighbourhood expectations for advice, triage, medicines support, prevention, and informal substitution for services that were previously delivered elsewhere. Yet accessibility alone does not establish an unlimited professional obligation to absorb unmet demand. This article develops a normative Fair-Burden Framework for determining how community claims should be translated into pharmacy responsibilities when local health-service capacity is uneven. The analysis integrates evidence on pharmacy deserts, service closure, spatial inequity, extended pharmacy roles, working conditions, moral distress, resilience, and service implementation with distributive-justice reasoning. The framework separates five questions that are often collapsed: how strong the community claim is; whether the requested response fits pharmacy competence and authority; whether usable organizational and workforce capacity exists; whether the additional burden is proportionate to the benefit and risk avoided; and which responsibilities remain with organizations, commissioners, and public systems even when pharmacies provide temporary assistance. Workforce protection is treated as a justice constraint because staff safety, time, moral agency, and capacity affect the legitimacy of further burden assignment. The framework therefore permits increased pharmacy responsibility where unmet need is serious, alternatives are weak, the response is role-compatible, and adequate resources are supplied, while requiring redistribution when local accessibility is being used to compensate for avoidable system withdrawal. A fair neighbourhood obligation is consequently conditional: community pharmacy should provide proportionate, competent and feasible assistance, but responsibility for maintaining access cannot be transferred automatically to the provider that happens to remain most visible.

**Keywords:** Community pharmacy, Health-service withdrawal, Distributive justice, Workforce protection, Healthcare access, Professional obligations

### Introduction

Community pharmacy can become unusually consequential when the surrounding health-service environment contracts. Recent US mapping

demonstrates that some communities either lack convenient pharmacy access altogether or depend heavily on a single “keystone” pharmacy whose loss would substantially worsen local access [1]. Pharmacy scarcity can also coexist with wider social vulnerability and poor access to primary care, meaning that the burden attached to one remaining pharmacy may arise within a much broader pattern of healthcare deprivation [2]. These conditions make community pharmacies important local institutions, yet importance is not equivalent to unlimited responsibility.

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The distribution of access is also unequal. Pharmacy availability and closure have been patterned by neighbourhood race and ethnicity, with Black and Hispanic/Latino communities in large US cities experiencing fewer pharmacies and greater exposure to pharmacy deserts [3]. Closure is not merely a geographic event. Among older adults receiving cardiovascular medicines, closure of a usual pharmacy was followed by persistent reductions in medication adherence, with some groups experiencing greater disruption than others [4]. The ethical problem therefore begins with real consequences: when a health-service node disappears, the remaining local providers encounter stronger claims from patients whose alternatives have narrowed.

The central question is how those claims should be allocated. A neighbourhood may have compelling needs without every accessible professional becoming responsible for meeting all of them. Community pharmacists also operate within legal scopes, organizational arrangements, staffing limits, commercial structures, and wider health systems whose own decisions shape local scarcity. A distributive account is therefore required: one that recognizes need without converting proximity into compulsory substitution, acknowledges professional obligations without treating them as limitless, and incorporates workforce protection as part of justice rather than as a secondary managerial concern.

#### *Withdrawal of local health services and the expansion of pharmacy claims*

Service withdrawal alters the local distribution of expectations before it alters formal professional roles. Community-pharmacy infrastructure itself is vulnerable: national US evidence has shown meaningful pharmacy closure over time, with closure patterns differing by ownership and local context [5]. More recent work examining anticonvulsant dispensing likewise indicates that pharmacy closure can be followed by disruption in prescription-filling behaviour [6]. These findings establish an important starting point for the present argument. A pharmacy that remains open after another service disappears does not stand in an unchanged environment. It faces a modified field of demand.

Community pharmacies are particularly exposed to this shift because patients encounter them frequently. Medicare beneficiaries in one national analysis visited community pharmacies substantially more often than primary-care physicians, with particularly pronounced

pharmacy contact in rural settings [7]. Frequent contact creates visibility, and visibility can transform unmet need into direct requests: advice about symptoms, explanations of treatment, assistance obtaining medicines, support with chronic disease, vaccination, minor-ailment management, or guidance about where else to seek help. The resulting “claim exposure” is ethically significant because the pharmacy is confronted with the need, yet exposure does not settle who ultimately owns the responsibility.

System design can alter that exposure. US state experience with telepharmacy illustrates that access deficits are partly responsive to regulatory and organizational arrangements rather than being fixed features of geography [8]. This matters normatively. When a public or commissioning system has policy instruments capable of redistributing access, the persistence of a local gap cannot automatically be treated as a burden that the nearest bricks-and-mortar pharmacy must privately absorb. The withdrawal of other health services expands claims upon pharmacy, but the legitimacy and extent of the resulting duties must be assessed separately.

#### *Why accessibility does not create unlimited obligation*

The intuitive case for expanding pharmacy responsibility rests heavily on accessibility. National spatial analysis shows that most US residents live within relatively short driving distances of a community pharmacy, although rural communities depend disproportionately on independent and franchise pharmacies [9]. Accessibility is therefore a genuine institutional asset. Yet it is multidimensional. Historical redlining has been associated with poorer contemporary spatial access to pharmacies, illustrating that even geographic availability reflects accumulated institutional and neighbourhood inequalities [10]. A pharmacy can be nearby in one setting, scarce in another, and locally indispensable in a third.

Physical availability also says little about whether a particular service can be delivered safely and well. Stakeholders evaluating community-pharmacy quality have emphasized communication, information provision, knowledgeable staff, convenience and the working environment [11]. These dimensions reveal why opening hours and distance cannot function as complete proxies for service capacity. A pharmacy may be physically accessible while lacking the staffing, time, space,

information infrastructure or authority required for an additional clinical function.

Evidence on extended roles reinforces this distinction. A realist evaluation of community-pharmacy service development found that expanded roles emerged through interacting contextual conditions and mechanisms; no single implementation lever was sufficient [12]. The normative implication is important. Accessibility can establish that a pharmacy is well positioned to respond, but obligation should depend on whether the relevant response is professionally legitimate, operationally feasible and adequately supported. Where these conditions are absent, a duty to assist may take the form of triage, referral, temporary mitigation or escalation to another accountable actor rather than direct substitution for the withdrawn service.

This distinction also prevents the health system from using accessibility as a mechanism of responsibility transfer. If location alone generated duty, the provider that remained open longest would progressively inherit the responsibilities of every service that withdrew. Such an allocation would reward system retreat by loading the residual institution. A defensible account must instead ask whether accessibility creates opportunity, whether opportunity can be converted into competent action, and whether the costs of that conversion are proportionately shared.

#### *Distributive-justice foundations*

A fair allocation of health-service burdens requires more than a description of who can be reached. Ethical analysis of healthcare-worker obligations has emphasized that duty to care and worker wellbeing must be balanced through proportionality, including the seriousness of the need, risks to staff, and the feasibility of protective measures [13]. The present problem is broader than emergency worker protection, but the underlying principle transfers: professional obligations may be substantial while still being bounded by the conditions under which they are imposed.

The source of a burden also matters. Contemporary bioethics distinguishes moral stress generated by the routine functioning of overstretched systems from purely individual psychological difficulty [14]. This distinction is highly relevant when pharmacies are expected to compensate for shrinking local services. A pharmacist may be able to resolve an immediate patient problem while simultaneously facing organizational conditions that make repeated resolution unsustainable. The ethical

issue is therefore not exhausted by whether the professional can do something once. It includes whether a system is repeatedly shifting foreseeable responsibilities onto individuals who lack the authority or resources to change the upstream cause.

At the same time, constraint should not be equated automatically with injustice. Conceptual work on moral distress emphasizes the need to determine whether a constraint actually compromises legitimate moral agency rather than classifying every difficult professional circumstance as ethically wrongful [15]. A Fair-Burden account therefore requires discrimination. Some burdens are inherent to healthcare practice and appropriately borne by professionals; some can be mitigated through better organization; some are temporarily justified by urgent patient need; and some represent avoidable displacement of system responsibility. Distributive justice asks which category applies, to whom, under what conditions, and for how long.

Three principles follow. First, need matters: stronger and more urgent community claims can justify greater professional effort. Second, capacity matters: an obligation that ignores whether competent and safe performance is possible is poorly allocated. Third, reciprocity matters: institutions that expect pharmacies to carry expanded responsibilities should provide resources, authority, coordination and protection commensurate with those responsibilities. Together these principles prevent both extremes—treating pharmacies as morally indifferent to local service withdrawal, or treating them as inexhaustible substitutes for the rest of the health system.

#### *Community need and neighbourhood claims*

Neighbourhood claims differ in moral strength. A request generated by inconvenience is not equivalent to one involving interruption of an essential medicine, serious deterioration risk, or the disappearance of the only realistically accessible source of support. Local dependence, social vulnerability and lack of alternatives can therefore intensify the claim presented to a pharmacy. Evidence on pharmacy deserts and spatial inequity reinforces that these factors are unevenly distributed across communities [1]. A fair framework must recognize that identical professional responses can have different distributive consequences depending on the alternatives available to the patient.

Claim strength, however, should be distinguished from deliverability. Research examining a proposed

community-pharmacy bladder and bowel service identified staff capacity, training, funding, information technology, guidance and policy support as material determinants of feasibility [16]. The lesson is not confined to that specific service. Unmet need can establish a compelling reason for action while leaving open which actor should act and what form the response should take. A pharmacy may owe direct service, temporary assistance, structured referral, advocacy for reinstated provision, or escalation to a commissioner depending on the relationship between need and capability.

The neighbourhood claim is therefore best understood as having several dimensions: seriousness of the need; degree of local dependency; availability of realistic substitutes; inequity associated with non-response; fit with pharmacy competence; and feasibility of a safe response. These dimensions should be considered jointly without collapsing them into a numerical score. Their function is discriminative. They prevent a low-stakes request with many alternatives from being treated like an urgent access failure, and they prevent severe need from being mistaken for proof that the pharmacy possesses the means or authority to resolve it.

The resulting configurations are summarized in **Table 1**.

**Table 1.** Neighbourhood claim configurations that alter the strength and form of community-pharmacy obligation

| Neighbourhood claim configuration                                  | Local-dependence signal                                                                                                   | Availability of credible alternatives | Fit with ordinary pharmacy role | Capacity question raised                                                              | Fair-burden implication                                                           |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| <b>Acute interruption of medicine access</b>                       | Patient faces near-term loss of treatment continuity                                                                      | Weak or time-sensitive                | Usually high                    | Can immediate continuity be protected safely?                                         | Strong claim for prompt assistance, mitigation or escalation                      |
| <b>Progressive withdrawal of routine local care</b>                | Pharmacy becomes the most visible remaining health contact                                                                | Variable but declining                | Mixed                           | Which functions can be absorbed without displacing core pharmacy work?                | Obligation should be differentiated by function rather than transferred wholesale |
| <b>Inequitable neighbourhood dependence</b>                        | Scarcity overlaps with social vulnerability or historically poor access                                                   | Persistently weak                     | Depends on requested service    | Would non-response deepen an existing access inequity?                                | Equity strengthens the claim but does not eliminate role and capacity limits      |
| <b>High-contact request outside pharmacy authority</b>             | Patient repeatedly presents because the pharmacy is easy to reach                                                         | Alternatives may be poor              | Low                             | Can the pharmacy safely triage, refer or advocate without assuming unauthorized care? | Duty may centre on navigation and escalation instead of substitution              |
| <b>Pharmacy-addressable need with adequate support</b>             | Need falls within competence and resources are available                                                                  | Alternative provision may still exist | High                            | Is the added workload proportionate and sustainable?                                  | Strong case for direct pharmacy provision                                         |
| <b>System-generated need requiring non-pharmacy infrastructure</b> | Withdrawal creates a gap that depends on diagnostics, prescribing authority, longitudinal records or public commissioning | Weak                                  | Low or partial                  | Which actor retains nondelegable responsibility?                                      | Pharmacy may mitigate immediate harm while responsibility remains upstream        |

**Table 1** separates claim strength from burden ownership. Severe need can create a strong moral reason for response without determining that the entire response must be delivered by the pharmacy. This distinction becomes essential when professional obligations are considered directly.

#### *Professional and service obligations*

Community pharmacists do have affirmative obligations that exceed passive referral. Their professional role includes the safe supply of medicines, clinically responsible advice, identification of medication-related problems, communication, and context-dependent public-health or clinical services. The appropriate distribution of this work within the pharmacy team can

also differ by task. A best-worst scaling study found distinct pharmacist and technician preferences concerning the allocation of logistical and clinical activities [17]. Preferences do not define legal scope, yet they demonstrate that “the pharmacy” is not a single undifferentiated provider; responsibility is enacted through professionals with different roles, skills and workload positions.

Professional duty becomes more complex as additional services accumulate. Qualitative evidence from Australian community pharmacists has shown that expanded service provision can coexist with insufficient resources, organizational expectations and workplace strain [18]. This does not negate the duty to provide care. It indicates that the content of that duty is partly shaped by whether the organization has created conditions in which competent care can actually be delivered. A professional obligation detached from staffing, workflow and organizational support risks becoming an instruction to compensate individually for structural deficiencies.

Disruptive events make the distinction between assistance and ownership especially visible. Community pharmacists managing medicine shortages have described substantial additional work generated by supply disruptions and other crises [19]. Their professional role may require active problem-solving, communication and mitigation because patients cannot simply be abandoned when upstream systems fail. Yet performing this work does not make the pharmacy responsible for the underlying supply failure. The same principle applies when other health services withdraw. A local pharmacy may acquire stronger duties of response while the organization, commissioner, regulator or public system retains responsibility for restoring adequate service capacity.

The professional-duty question can therefore be framed through role fit. Where a requested response lies within competence and authority, protects patients from substantial avoidable harm, and can be delivered safely, the case for pharmacy action is strong. Where the task falls outside that domain, responsibility may instead involve navigation, communication, escalation or temporary mitigation. What pharmacy owes is determined by the relationship between patient need and legitimate professional capacity, not by residual visibility alone.

#### *Workforce protection as a justice constraint*

Workforce capacity is frequently treated as an operational detail that enters only after service obligations have been defined. In the present argument it has normative status. If additional obligations are assigned without considering whether staff can carry them safely, the resulting allocation can transfer system risk to practitioners and patients simultaneously.

Recent survey evidence illustrates the concern. Community pharmacists have reported high levels of workplace stress and staffing difficulty, with stress associated with perceived difficulty providing quality care [20]. The evidence must be interpreted carefully because cross-sectional self-report data do not establish a causal error rate. Indeed, Swedish pharmacists surveyed during the COVID-19 pandemic frequently reported increased workload and poorer psychosocial conditions while many still perceived patient safety as unaffected [21]. This discordance is important. It prevents a simplistic inference that every increment in workload produces immediate measurable harm. Workforce protection rests on a broader justice argument: sustained responsibility should not depend on professionals continually absorbing additional demands until observable harm finally appears.

Qualitative evidence reinforces the relevance of professional wellbeing. Community pharmacists responding during the pandemic described experiences of being treated as components of medicine supply rather than fully recognized healthcare professionals, alongside substantial wellbeing pressures and insufficient support [22]. Research using the job demands-resources model similarly found that practical and emotional demands contributed to burnout, while workplace and governmental resources could buffer those demands [23]. The distributive implication is reciprocal: where health systems expect more clinical responsibility, they should also supply the resources that make such responsibility sustainable.

Pharmacy teams can adapt impressively under pressure. Resilience research during the pandemic documented changes in work processes that helped community pharmacies maintain patient safety [24]. Adaptive performance, however, should not be interpreted as proof of unused capacity. A system that repeatedly relies on extraordinary adaptation can transform resilience from a protective capability into a justification for further burden transfer. This is particularly concerning where time constraints affect professional moral agency. Pharmacy-specific research has identified lack of time as

a prominent source of moral distress among community pharmacists [25].

Justice also requires attention to the whole pharmacy workforce. A recent narrative review of community-pharmacy technician wellbeing highlights the importance of role clarity, protection, recognition, connection and supportive working conditions [26]. Expanded community obligations are therefore not carried by pharmacists alone. They propagate through technicians, support staff, workflow, supervision and the distribution of routine tasks. Any burden-allocation rule that counts only pharmacist competence while ignoring the wider workforce misrepresents the capacity on which safe service depends.

Workforce protection should consequently function as a constraint on how obligations are discharged, not as a blanket exemption from responsibility. Strong community claims may justify temporary intensification of effort, especially where serious harm is imminent. But repeated or indefinite expansion requires reciprocal resourcing, redesign or redistribution. When safe staffing, time, infrastructure or moral agency become materially constrained, justice may require responsibility to move upward to organizational or public-system actors with greater capacity to change those conditions.

#### *Development of the fair-burden framework*

The evidence reviewed above supports a normative distinction between exposure to need and ownership of the burden created by that need. Community pharmacies may be highly exposed because they are local, visible, frequently visited and able to respond to many medication-related problems. Exposure strengthens the reason to engage with a claim; it does not determine that the pharmacy should carry every consequence of service withdrawal. The Fair-Burden Framework therefore treats obligation as the outcome of several linked judgments rather than a direct function of accessibility.

The first judgment concerns claim strength. Urgency, local dependency, inequity and the absence of realistic alternatives increase the moral weight of the neighbourhood claim. The second concerns role fit: whether the requested response lies within professional competence, lawful authority and the service functions that community pharmacy can reasonably perform. The third concerns usable capacity, meaning actual staffing, time, workflow, infrastructure and organizational support available after existing obligations are considered. The fourth concerns proportionality: whether the additional

burden is reasonable in relation to the seriousness of the need, the benefit achievable and the duties that may be displaced. The fifth concerns system responsibility. Some responsibilities remain with commissioners, regulators, health-service organizations and public authorities even when community pharmacy can temporarily reduce the harm caused by their absence.

These judgments interact. Strong need can justify greater pharmacy effort where role fit and usable capacity are also strong. Weak alternatives can intensify duties of temporary assistance even when full substitution is inappropriate. Conversely, a highly accessible pharmacy with inadequate authority or exhausted capacity may owe navigation and escalation while the primary obligation moves upstream. This allocation is dynamic because capacity can be expanded through staffing, funding, technology, delegation and collaboration. Finnish evidence on community-pharmacy crisis management illustrates both the value and limits of organizational coordination: some forms of shared decision-making and collaboration were associated with resilience or resources, while other seemingly desirable crisis-management arrangements showed no clear advantage [27]. Coordination therefore matters through its actual mechanisms, not by label alone.

The framework also introduces a redistribution threshold without converting it into a numerical cutoff. The threshold is crossed when further local absorption would create a disproportionate burden relative to the pharmacy's role and usable capacity, especially where the underlying deficit originates in avoidable system withdrawal or where another actor possesses greater authority to restore access. Crossing that threshold does not dissolve the pharmacy's obligations to patients already at its counter. It changes the justified form of the response: immediate mitigation may remain local while responsibility for durable resolution shifts to actors capable of financing, commissioning, staffing or redesigning care.

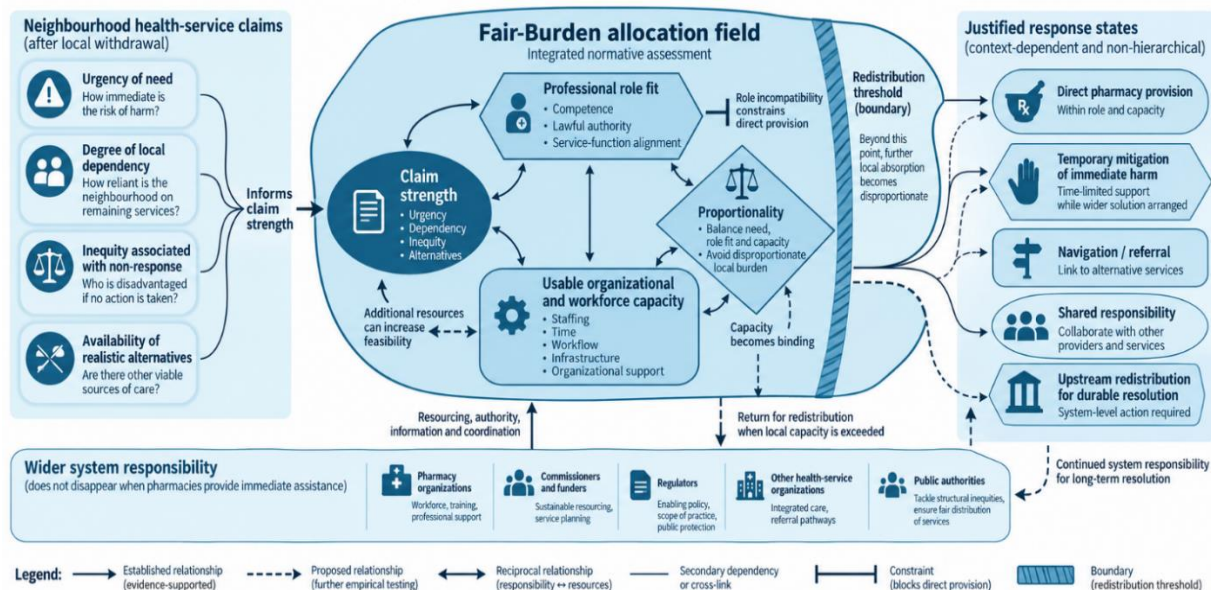
This prevents two symmetrical errors. One is abandonment: treating service withdrawal as someone else's problem even when a pharmacy can prevent substantial immediate harm through competent action. The other is residual-provider capture: treating continued accessibility as sufficient reason for the pharmacy to absorb every function that other services no longer perform. Fair allocation occupies the space between these positions. It recognizes stronger duties when need is serious and pharmacy action is feasible, while preserving

a principled route for responsibility to move upward when local capacity becomes binding.

The framework's central relationships are summarized in **Figure 1**.

### From Unmet Need to Fair Responsibility

A normative allocation framework for community-pharmacy obligations after local health-service withdrawal



**Figure 1.** Fair-Burden allocation field for residual neighbourhood health-service claims

#### Allocating responsibility under unequal local capacity

The Fair-Burden Framework becomes most consequential when neighbourhood need is similar but local pharmacy capacity is not. Extended pharmacy services depend on contextual supports rather than accessibility alone [12], and implementation research shows that time, staffing, funding, information technology and policy support can determine whether a seemingly appropriate service is actually deliverable [16]. Responsibility should therefore vary with usable capacity, not merely with whether a pharmacy exists at a location.

Where competence, authority and resources are strong, pharmacies can reasonably bear a larger share of locally unmet need. Internal task redistribution may create additional capacity where work can appropriately move between pharmacists and technicians [17]. Conversely, service strain, medicine-supply disruption and inadequate organizational resources can narrow the range of responsibilities that can be absorbed without

displacing existing duties [18]. External disruption may still require immediate mitigation, but performing that mitigation does not transfer ownership of the upstream failure to the pharmacy [19].

Unequal capacity also changes what fairness requires from the wider system. When one pharmacy can safely expand while another cannot, identical obligations may be inequitable rather than equal. The appropriate response is to distribute responsibility according to relevant capability while ensuring that lower-capacity providers are not penalized for structural constraints they cannot control. Crisis-management evidence suggests that organizational coordination and shared decision-making can sometimes improve resilience and resources, although such effects depend on the specific mechanism and are not uniformly beneficial [27]. Capacity is therefore partly produced by institutional arrangements and can be redistributed through financing, staffing, delegation, authority and coordination.

These allocation conditions are summarized in **Table 2**.

**Table 2.** Fair-Burden allocation under unequal community-pharmacy capacity

| Allocation condition | Community-pharmacy position | Appropriate local responsibility | Responsibility that remains shared or upstream | Justice rationale |
|----------------------|-----------------------------|----------------------------------|------------------------------------------------|-------------------|
|----------------------|-----------------------------|----------------------------------|------------------------------------------------|-------------------|

|                                                                |                                                               |                                                             |                                                                               |                                                                                 |
|----------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <b>Strong claim, strong role fit, adequate usable capacity</b> | Pharmacy is well placed to act                                | Direct provision where safe and authorized                  | Continued system support and monitoring                                       | High need and high feasible capability justify greater local contribution       |
| <b>Strong claim, partial role fit</b>                          | Pharmacy can address only part of the need                    | Immediate mitigation, advice, navigation or limited service | Durable clinical management remains with the competent service/system actor   | Assistance should match competence rather than expand implicitly                |
| <b>Strong claim, low usable capacity</b>                       | Need is serious but local workforce/resources are constrained | Protect immediate safety and escalate                       | Organization, commissioner or public system must mobilize additional capacity | Serious need strengthens the claim but does not erase proportionality           |
| <b>Moderate claim, adequate alternatives</b>                   | Pharmacy is accessible but not uniquely necessary             | Reasonable assistance within ordinary practice              | Alternative services retain their normal responsibilities                     | Accessibility alone does not justify responsibility transfer                    |
| <b>System-generated service gap</b>                            | Pharmacy faces repeated residual demand                       | Temporary local response where justified                    | Structural restoration, commissioning and resourcing remain upstream          | The actor causing or governing the deficit cannot externalize its entire burden |
| <b>Emergency with imminent avoidable harm</b>                  | Ordinary allocation temporarily becomes insufficient          | Time-limited intensification within competence and safety   | Wider system remains accountable for rapid reinforcement and recovery         | Urgency can increase duty without converting an exception into permanent scope  |

The table does not represent a scoring system. Its purpose is to distinguish qualitatively different burden allocations that may arise from the same underlying community need.

#### *Thresholds, exceptions and boundary conditions*

Fair burden does not imply a fixed ceiling on professional obligation. In emergencies, serious and imminent avoidable harm can justify temporary intensification of pharmacy effort even when ordinary workload is already substantial. Ethical analysis of duty and worker protection supports proportional balancing rather than absolute rules [13]. Adaptive pharmacy practice during crisis conditions also demonstrates that teams can reorganize rapidly when circumstances demand it [24]. The exception remains bounded. Expanded responsibility becomes difficult to justify when the required activity lies outside competence or authority, when safe performance cannot be maintained, or when added work materially displaces essential existing obligations. Time constraints can become morally significant where professionals cannot act according to their legitimate clinical judgment [25]. Workforce protection therefore limits the form and duration of extra responsibility without eliminating the obligation to prevent immediate avoidable harm.

Context also matters. Evidence on burnout, work environment and service development comes from different jurisdictions and organizational settings [23].

No universal staffing ratio, workload score or numerical redistribution threshold can be inferred from these studies. The framework consequently treats thresholds as normative judgments grounded in role, risk, capacity and alternatives, not as empirically validated cut-points.

#### *Policy implications*

Health systems that expect pharmacies to undertake broader responsibilities should treat capacity creation as part of the policy itself. Telepharmacy policy demonstrates that access can be altered through system design rather than by relying exclusively on existing physical pharmacies [8]. Extended-service implementation similarly depends on organizational and policy supports [12]. Expansion should therefore be accompanied by financing, workforce planning, information access, referral pathways and authority appropriate to the functions being transferred.

Policy should also protect strategically important local pharmacies before dependency becomes crisis. Communities that rely heavily on a single pharmacy are vulnerable to further access loss [1], while previous closure patterns show that pharmacy infrastructure cannot be assumed to remain stable without supportive conditions [5]. A system that continuously shifts demand toward a remaining pharmacy while allowing that provider's capacity to erode creates the conditions for another withdrawal.

Workforce policy is equally central. Technician wellbeing, role clarity and recognition form part of the capacity required for sustainable community-pharmacy provision [26]. Expanding pharmacist responsibilities while ignoring the team that supports dispensing, logistics and patient flow miscalculates real service capacity. Fair policy therefore links additional expectations to reciprocal resourcing and preserves a route for responsibilities to move back toward commissioners or public agencies when local absorption becomes disproportionate.

## Results and Discussion

This article develops a distributive account of community-pharmacy responsibility under local health-service withdrawal. Its principal contribution is to separate exposure to community need from ownership of the resulting service burden. Community pharmacies are often highly accessible, frequently encountered and clinically capable institutions. Those characteristics can generate strong obligations. They do not establish that every unmet function of the surrounding health system should migrate to the pharmacy that remains open.

The strongest challenge to this position is practical: in many settings, community pharmacy may genuinely be the most effective marginal provider. Frequent patient contact supports that possibility [7], and expanded pharmacy services can succeed where appropriate implementation conditions exist [12]. The Fair-Burden Framework therefore does not presume redistribution away from pharmacy. It predicts greater pharmacy responsibility when claim strength, role fit and usable capacity align. Its discriminating claim is that this responsibility should remain conditional on proportionality and reciprocity rather than arising automatically from accessibility.

The framework also changes how workforce limits are interpreted. Evidence of stress, burnout or moral distress should not be converted into an automatic exemption from professional responsibility. Community-pharmacy teams have demonstrated substantial adaptive capability under pressure [24]. Yet resilience cannot be treated as proof of indefinite reserve. The coexistence of worsened workload with reports of preserved patient safety further cautions against both exaggerating immediate harm and ignoring accumulating strain [21]. Workforce evidence is therefore most appropriately used to judge the legitimacy and sustainability of burden assignment.

Several limitations remain. Much of the empirical access literature is US-based, while workforce and implementation studies come from heterogeneous healthcare systems. Most studies were not designed to test distributive-justice propositions directly. The framework therefore synthesizes empirical premises with normative reasoning rather than claiming empirical validation. Future research could compare how identical community needs produce different justified allocations when staffing, authority, alternatives and commissioning structures vary. It could also test whether explicit reciprocity—additional resources accompanying additional obligations—improves sustainability more effectively than responsibility expansion alone.

The broader implication is institutional. Local healthcare systems should not wait until a remaining pharmacy becomes overloaded before deciding who owns unmet need. Responsibility should be allocated prospectively across professionals, organizations and public systems, with mechanisms for escalation and redistribution when circumstances change. Such an approach preserves the distinctive accessibility of community pharmacy without allowing that accessibility to become a pathway through which broader service withdrawal is normalized.

## Conclusion

A community pharmacy owes its neighbourhood meaningful, competent and proportionate assistance when other health services withdraw, particularly where unmet need is serious and alternatives are weak. That obligation can include direct service, temporary mitigation, navigation, escalation or shared care. It does not amount to automatic ownership of every function abandoned elsewhere.

Fairness requires community need to be considered alongside professional role, usable workforce capacity, proportionality and the continuing responsibilities of organizations and public systems. Where pharmacies are equipped to do more, greater responsibility can be justified. Where further absorption would exceed legitimate role or sustainable capacity, justice requires redistribution rather than further loading the provider that remains most accessible.

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