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Turning Pharmacy Expertise into Public Health Influence Requires Collective Political Agency: Community Representation, Organizational Voice, and Action on Commercial Determinants of Health

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Abstract

Community pharmacy is increasingly positioned as a public-health setting, yet expertise, service reach, and professional trust do not themselves establish influence over the commercial and policy conditions shaping population health. This conceptual article develops a Collective Political-Agency Framework explaining how distributed pharmacy expertise can become legitimate public-health influence. It distinguishes professional capability from political access, voice, representation, agenda-setting capacity, and consequential influence. Political agency is treated as a collective accomplishment requiring organizational translation of expertise, representative legitimacy, coalition capacity, access to decision venues, and accountability to affected communities. The analysis situates pharmacy within the commercial determinants of health, where organized interests and public institutions already compete to shape agendas. The central claim is conditional: pharmacists and pharmacy organizations are more likely to exercise legitimate public-health influence when credible expertise is connected to accountable representation, coordinated organizational voice, coalition-building, and agenda access.

Keywords: Community pharmacy, Political agency, Commercial determinants of health, Professional advocacy, Community representation, Agenda setting

Introduction

Community pharmacy has a substantial public-health footprint. A systematic review shows that delivery of public-health interventions through community pharmacies depends on interacting practitioner, organizational, intervention, and contextual conditions [1]. Public-facing media also represent pharmacists in patterned ways, making professional visibility a distinct object of analysis [2]. Community pharmacies can extend public-health initiatives into accessible settings [3], while realist evidence on expanded roles shows that implementation depends on the mechanisms through which new responsibilities become usable in practice [4]. An overview of pharmacist-led pharmaceutical care further confirms substantive clinical and service expertise across multiple areas of care [5].

Capability and reach do not settle whether pharmacy can alter agendas, institutional priorities, regulatory choices, or commercial conditions. Pharmacists can participate in structured medicines-policy development [6], yet direct policy evidence shows that professional capacity may remain politically underused. In Ireland's COVID-19 vaccination programme, delayed pharmacy deployment was linked to institutional positioning, professional dominance, and weaknesses in cohesive pharmacy

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leadership [7]. International evidence on early-career pharmacy groups likewise demonstrates organized policy activity while leaving open whether participation changes decisions [8].

The article therefore asks how pharmacy expertise becomes politically consequential without losing legitimacy. It distinguishes voice from access, access from agenda-setting capacity, agenda access from decision consequence, and political effectiveness from legitimate representation.

The difference between public-health expertise and public-health influence

Public-health expertise is the capacity to recognize, interpret, and act on health problems using professional knowledge, evidence, service experience, and population-level reasoning. Community-pharmacy research shows that such expertise can support public-health interventions, but action remains conditioned by resources and organizational context [1]. Public visibility is another distinct capacity: media representation can shape recognition of pharmacy roles without conferring policy authority [2]. Likewise, evidence of pharmaceutical-care effectiveness establishes capability, not political influence [5].

Public-health influence concerns the capacity to affect which problems receive authoritative attention, how they are framed, who participates in decisions, which options remain feasible, and what policies or commitments follow. The Irish vaccination case matters because capability and policy consequence diverged [7]. Stakeholder participation can create access [6], and professional groups can create collective platforms [8], but neither guarantees agenda consequence.

This distinction changes measurement. Service counts, memberships, advocacy statements, or invitations may show activity. Influence requires a consequential political referent: agenda entry, altered framing, changed decision rights, resource reallocation, policy modification, or implementation commitment. Expertise is therefore a necessary input to credible advocacy, not influence itself.

Commercial determinants of health

The political problem becomes clearer when pharmacy is situated within the commercial determinants of health. Contemporary work defines these as systems, practices, and pathways through which commercial actors and political-economic arrangements shape health and equity [9]. This moves analysis beyond harmful products toward market governance and institutional relationships. Work on future directions correspondingly emphasizes policy and regulatory responses extending beyond individual behavior change [10].

Corporate influence is heterogeneous. A recent scoping synthesis identifies multiple forms of corporate activity affecting population health [11]. Pharmacy advocacy therefore enters a policy arena where other actors may possess established financial resources, access networks, and policy strategies. Yet actor-centered accounts are incomplete: structural analysis shows how market organization can shape health without a discrete lobbying event [12], and research on corporate-charity relationships illustrates how resource dependencies can distribute influence [13].

Accountability cannot therefore be reduced to identifying a harmful company. Public institutions structure and regulate markets [14], while corporate political activity can shape information, constituencies, legal environments, and agendas through organized strategies [15]. Pharmacy collective agency operates within this contested field, often under substantial resource and access asymmetries.

Political agency, voice and representation

Political agency is the capacity to act purposefully within processes allocating public attention, authority, resources, and rules. Evidence from nursing shows that political participation depends on individual capabilities as well as organizational and institutional facilitators and barriers [16]. The transferable point is that professional knowledge does not automatically become political agency.

Voice is the capacity to articulate a position in a consequential forum. Representation adds a relationship between the speaker and those whose interests are invoked. Political organization adds coordination, resources, and strategy. Advocacy-coalition scholarship increasingly treats coalitions as political organizations rather than loose collections of actors sharing beliefs [17].

These distinctions prevent shortcuts. A professional association can issue a statement without securing agenda access; a pharmacist can join a consultation without representing a community; a coalition can exist without enough organization to alter political attention. Voice, representation, organization, and influence are therefore related but non-equivalent.

Limits of individual pharmacist agency

Individual limits become visible when professional roles expand faster than institutional authority. A mixed-methods systematic review documents broad primary-health-care roles for community pharmacists alongside uneven health-system integration and recognition [18]. Work on pharmacists and the social determinants of health similarly locates potential action across patient, practice, and community levels [19]. Role breadth, however, does not create the authority, resources, or political access needed to perform every role effectively. An individual pharmacist can identify harm, recognize patterns of unmet need, collect local intelligence, and sometimes advocate directly. What one practitioner rarely creates alone is a durable constituency, accountable mandate, sustained policy analysis, access to multiple decision venues, or a coalition able to maintain an issue through political competition. The Irish vaccination case shows how professional capability can remain subordinate to wider institutional relations [7], while health-professional evidence shows how organizations expand or constrain political participation [16]. Political agency is consequently distributed across actors and levels rather than reducible to an individual attribute.

Why collective capacity matters

Collective capacity is the organized ability to combine distributed expertise, sustain action, allocate specialized work, mobilize resources, coordinate positions, form alliances, and enter political venues with continuity. International evidence on pharmacy organizations shows that professional groups can create platforms for policy engagement [8]. Coalition theory adds that coordination and strategy matter independently of shared concern [17]. Collective political work often requires repeated evidence production, relationship maintenance, negotiation, and response to opposition. A study of maternal and child health coalitions in Nigeria shows how coalition mechanisms can help sustain political priority when supportive contextual conditions exist [20]. The lesson is conditional: coalitions can create capacities that isolated organizations lack, but effects depend on leadership, relationships, institutional opportunity, and the political environment. A larger membership list is therefore not collective political agency unless organization changes what actors can do.

Development of the political-agency framework

The framework integrates seven capacities: credible public-health expertise, community representation, professional and organizational voice, mobilizable organizational resources, coalition capacity, agenda access, and accountability. The first six concern whether pharmacy can become politically consequential; the seventh concerns whether doing so remains legitimate. No single capacity is sufficient.

Distributed expertise supplies issue recognition and evidence. Organizational voice converts dispersed knowledge into positions that can persist beyond individual encounters. Resources sustain analysis, communication, negotiation, and policy engagement. Coalition capacity extends action when pharmacy needs broader legitimacy, complementary resources, or access it cannot secure alone. Agenda access marks the point at which claims enter venues where priorities, funding, regulation, or implementation can change.

Institutional opportunity can enable or block these capacities. Legitimacy creates a separate constraint: pharmacy organizations may be effective while weakly connected to community priorities, or may invoke communities without giving them meaningful influence. Political effectiveness and legitimate representation must therefore be assessed separately.

Figure 1 maps these relationships as a multilevel political field rather than a linear advocacy pipeline. Solid connectors indicate literature-supported relationships; dashed connectors indicate theoretical relationships advanced here; bidirectional links indicate reciprocal influence and accountability feedback.

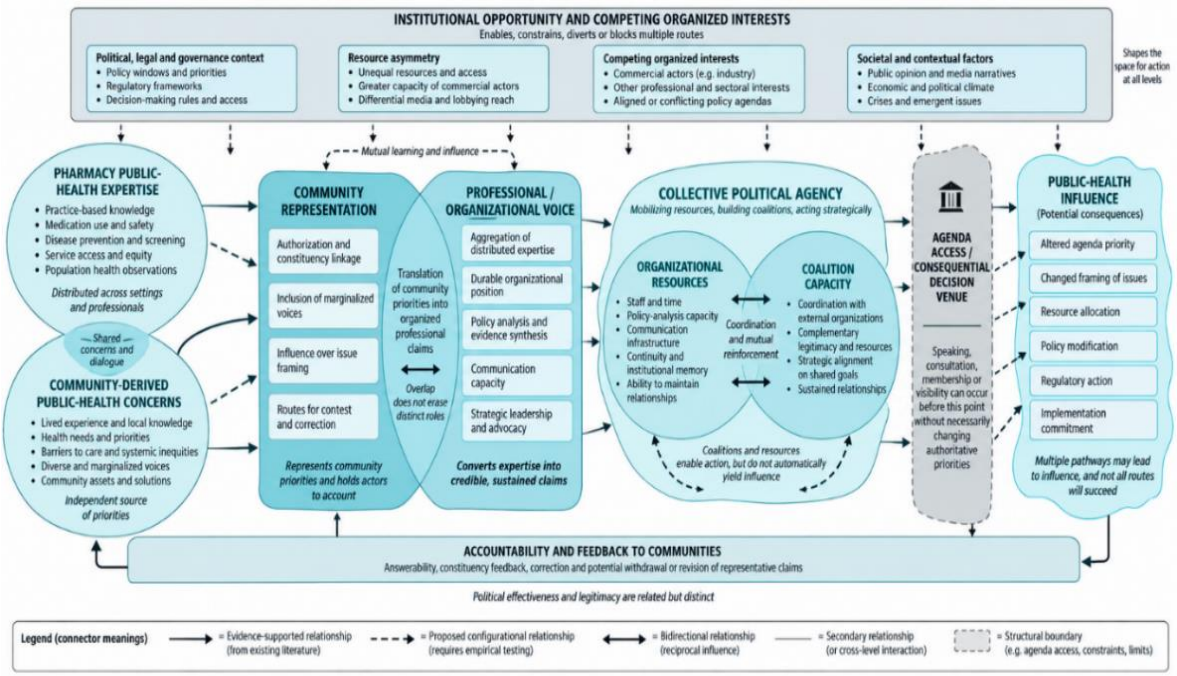

Figure 1. Collective political agency as the translation of pharmacy expertise into legitimate public-health influence

Community representation

Community representation supplies legitimacy that professional expertise cannot create by itself. Public-health scholarship distinguishes partnership from consultation by asking whether communities participate in governance, priority setting, and consequential decisions [21]. A scoping review of public engagement in health policy similarly shows that engagement varies in form, stage, and reported influence [22]. "Community voice" is therefore too imprecise unless the relation between participants and decisions is specified.

Power is central. A systematic review of co-production found that participatory labels do not ensure that decision control is shared [23]. During COVID-19, patient representatives likewise occupied formal roles within layered institutional structures that could constrain influence [24]. Procedural quality also matters: review and Delphi work identifies explicit principles for meaningful public involvement [25], while patient and family advisors describe engagement in terms inseparable from partnership and power [26]. An advisory seat cannot therefore be treated as representative authority when priorities and final positions remain professionally predetermined.

Representation also requires a constituency relationship. A patient-derived model asks the basic question, "Who represents me?", highlighting the link between representatives and those whose interests they claim to carry [27]. Research on embedded public involvement shows that tacit and explicit expectations can diverge unless roles are negotiated openly [28]. Legitimate arrangements therefore need an intelligible basis of authorization, role clarity, and a route for represented people to contest or correct collective positions.

Equity adds another requirement. Work mobilizing lived and living experience shows its value in health-equity assessment and priority formation [29]. Research with Black racial-minority advisors similarly illustrates how dedicated structures can amplify perspectives that routine processes may underrepresent [30]. Such participation should not be confused with statistical representativeness; its value lies in exposing priorities, burdens, and forms of exclusion that professional organizations may otherwise miss.

Table 1 translates these distinctions into representation conditions. The rows are alternative situations, not a maturity ladder.

Table 1. Representation conditions that determine whether pharmacy collective voice can legitimately invoke community interests

Representational situation	Basis for speaking with or for a community	Community influence over issue framing	Constituency linkage	Ability to contest or correct the position	Political-agency implication
Open consultation	Invitation to contribute views	Limited; agenda commonly preset	Weak or unspecified	Episodic	Supplies information but does not itself authorize representative claims
Standing advisory participation	Ongoing deliberative role	Partial and dependent on decision rights	Stable but sometimes indirect	Possible when feedback routes exist	Can strengthen legitimacy if participation changes framing or response
Constituency-linked representation	Explicit relationship to an identifiable group or network	Shared or negotiated	Clear authorization and accountability	Expected and routinized	Supports stronger claims that advocacy reflects represented priorities
Lived-experience partnership	Experiential authority grounded in direct exposure	Potentially substantial for defining burdens and acceptable responses	Experiential rather than statistically representative	Must accommodate plurality and disagreement	Adds knowledge and legitimacy unavailable from professional expertise alone
Underrepresented-community advisory structure	Deliberate inclusion where routine processes marginalize voices	Depends on access to consequential decisions	Must be actively maintained	Essential	Can correct exclusion when influence and accountability are built in
Profession-led claim without accountable community linkage	Professional inference about community interests	Predominantly professional	Absent or weak	Limited	May identify a real concern but cannot establish representative authority

Professional and organizational voice

Professional voice becomes politically meaningful when dispersed observations from practice can be converted into a position that an organization is willing and able to sustain. The Finnish Rational Pharmacotherapy Action Plan illustrates how pharmacy stakeholders can contribute within structured, multi-actor policy processes [6]. Conversely, the delayed involvement of community pharmacies in Ireland's COVID-19 vaccination programme shows how expertise may remain politically weak when professional leadership is fragmented or when other professions occupy stronger institutional positions [7]. International pharmacy organizations provide another route: organized professional groups can create platforms through which policy concerns, technical expertise, and professional priorities are articulated collectively [8].

Organizational voice therefore requires more than issuing statements. Health-professional evidence suggests that political participation is affected by organizational resources, expectations, leadership, and opportunities for engagement [16]. Coalition theory likewise distinguishes a politically organized collective from actors who merely share interests or beliefs [17]. For pharmacy, this implies capacities for policy analysis, internal deliberation, position formation, relationship management, communication, and continuity across electoral or administrative cycles.

The legitimacy of that voice depends on how positions are formed. An organization may speak efficiently for occupational interests while weakly representing public-health priorities or communities affected by commercial determinants. The framework therefore treats professional voice as a translation function between distributed expertise, represented claims, and political action. Translation can be technically strong yet normatively weak if organizational positions are insulated from the constituencies invoked in their name.

Coalition and agenda-setting capacity

Organizational voice still operates within a crowded political environment. Coalitions can extend a profession's reach by joining complementary expertise, constituencies, resources, and institutional access. Advocacy-coalition scholarship emphasizes organization, coordination, and strategic action rather than the mere coexistence of actors who favor the same policy direction [17]. Empirical work on maternal and child health shows that coalitions can sustain political

priority when relationships, coordination, leadership, and contextual opportunity align [20].

Agenda setting creates a further test. An issue may be well evidenced without becoming politically prioritized. Comparative research across 30 European countries found that antimicrobial-resistance agenda setting varied with political and institutional conditions rather than following automatically from the seriousness of the problem [31]. Pharmacy organizations operating on commercial determinants therefore compete for attention in settings where corporations and other organized interests may already deploy sophisticated political strategies [15].

Collective influence is consequently configurational. A pharmacy organization may possess strong expertise but weak access; a coalition may possess access but insufficient agreement; a representative alliance may possess legitimacy but lack policy-analysis capacity; and an issue may reach a consultation while remaining outside the authoritative agenda. **Figure 2** represents these alternative routes, blocked routes, and feedback relations without treating coalition formation as a guaranteed progression toward policy impact.

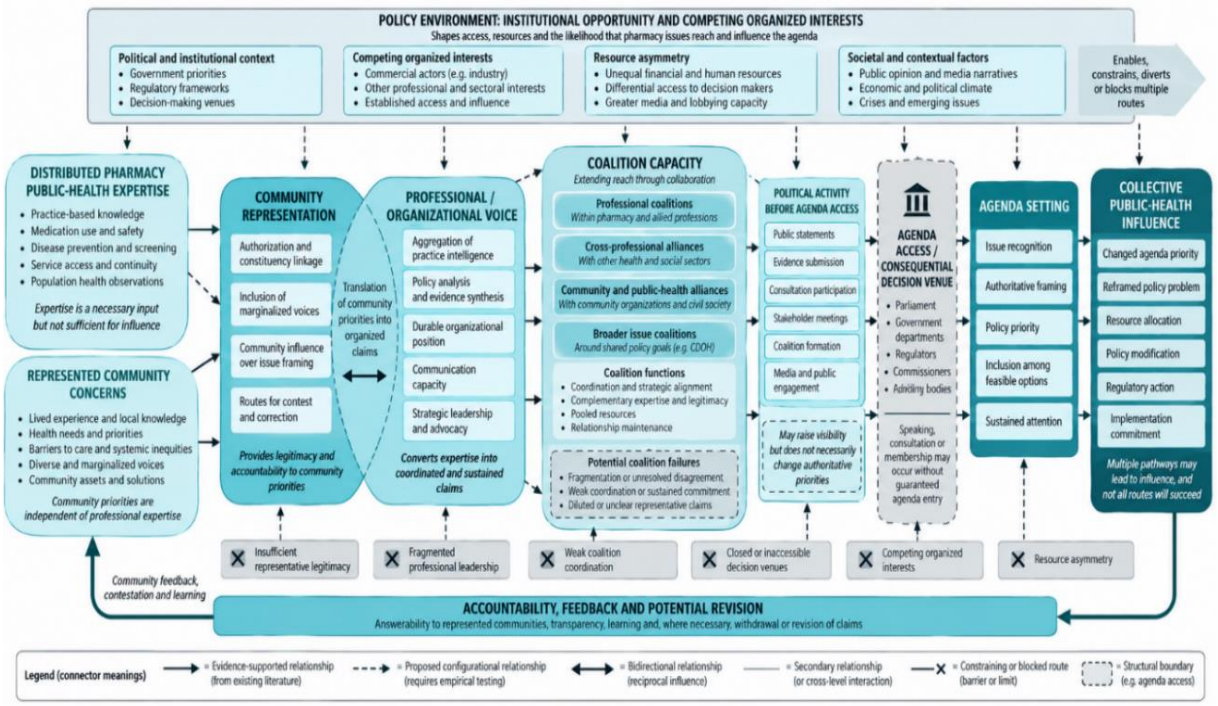

Figure 2. Coalition and agenda-setting configurations linking distributed pharmacy expertise to collective public-health influence

Legitimate forms of collective action

Political agency requires an action repertoire, but effectiveness does not by itself determine legitimacy. The commercial determinants literature establishes that population-health problems can arise through corporate practices, institutional arrangements, and wider political-economic structures [9]. Responses may therefore legitimately target different objects: public information, professional standards, organizational policy, market rules, regulation, commissioning, or legislation. System-level public-health scholarship supports governance responses that extend beyond attempts to modify individual behavior [10].

The appropriate form of action also depends on the mechanism being challenged. Corporate activities influencing health are heterogeneous [11], and structural accounts caution against assuming that every harmful condition can be corrected by confronting a single identifiable actor [12]. Interorganizational dependencies may create further complexity where organizations simultaneously receive resources from and seek to constrain commercial actors [13]. Public institutions

retain responsibility for the rules governing these relationships [14].

Collective pharmacy action can therefore range from evidence submission and public communication to coalition advocacy, organizational refusal, regulatory engagement, and support for legislative change. Corporate political activity research demonstrates that other actors employ multiple pathways to shape policy [15], while coalition theory shows why coordinated organization may matter when isolated action has little leverage [17]. Coalition evidence also cautions that action remains conditional on context and political opportunity [20].

Table 2 differentiates legitimate action situations according to the political object, pharmacy's authority and capacity, representative grounding, and the type of collective leverage required. These are alternative allocations, not sequential stages.

Table 2. Matching collective pharmacy action to the political object, representative basis, and available authority

Political situation	Immediate object of action	Required collective capacity	Representative condition	Legitimate pharmacy action	Principal limit
Evidence is absent from an active policy process	Information and framing	Evidence synthesis and organizational voice	Community implications identified but no claim of exclusive representation	Submit evidence, frame pharmacy-relevant consequences, request deliberation	Evidence submission does not establish agenda control
A recurring practice problem reflects organizational policy	Pharmacy organization or chain governance	Internal aggregation, leadership access, escalation routes	Affected patient/community concerns incorporated where relevant	Collective internal advocacy, governance escalation, policy revision request	Occupational convenience cannot substitute for public-health justification
Harm depends on rules controlled by regulators or commissioners	Regulatory or commissioning rule	Policy analysis, sustained professional organization, external relationships	Representative claims traceable to affected populations	Regulatory engagement, consultation response, formal policy advocacy	Pharmacy should not claim authority beyond its expertise or constituency
The problem crosses professional or sectoral boundaries	Shared policy arena	Coalition formation and coordination	Coalition composition should include actors affected by the policy	Cross-professional or civil-society coalition action	Coalition agreement may dilute or distort represented priorities
Commercial actors possess stronger organized access to decision makers	Political agenda and policy framing	Strategic coalition capacity, communications, venue access	Community legitimacy and conflict-of-interest safeguards are explicit	Countervailing collective advocacy, transparency demands, regulatory proposals	Political effectiveness does not excuse weak accountability
A population-health concern is real but pharmacy has little relevant authority or distinctive expertise	Policy domain led more legitimately by another actor	Recognition of role limits and referral of political leadership	Community claim remains acknowledged	Support, ally with, or defer to actors with superior mandate	Collective action should not become professional territorial expansion
Representative legitimacy is disputed or heterogeneous	Collective position itself	Deliberation, constituency feedback, correction mechanisms	Disagreement is visible rather than erased	Reopen consultation, revise or qualify the position, permit plural advocacy	Organizational unity must not be manufactured by suppressing dissent

Accountability for representation

Representation creates obligations after a position has been articulated as well as before it is formed. Public-health partnership models emphasize the difference between community participation and peripheral consultation [21], while policy-engagement reviews show that the depth and reported impact of participation vary widely [22]. Accountability therefore requires mechanisms through which communities can learn what was advocated, see how their contributions were interpreted, and challenge positions that no longer reflect their priorities.

Power sharing is especially important when organizations possess greater technical, financial, or

procedural resources than community participants. Co-production research demonstrates that participatory language can coexist with limited redistribution of control [23]. Patient-representation research similarly shows that formal inclusion within institutional structures does not guarantee influence [24]. Principles for high-quality public involvement [25] and advisor accounts emphasizing power and partnership [26] reinforce the need to examine decision rights rather than attendance alone.

A representative relationship also needs an answer to the constituency question. Patient-derived research explicitly asks who representatives speak for [27], while studies of embedded public involvement show that tacit assumptions can undermine participation when expectations remain unclear [28]. Lived experience can contribute knowledge unavailable through professional expertise [29], and dedicated advisory arrangements may improve the visibility of historically marginalized perspectives [30]. Yet no individual participant should be treated as statistically or morally representative of an internally diverse population.

For collective pharmacy advocacy, accountability should therefore include disclosure of whose interests are being represented, how participants were selected or engaged, where disagreement remains, how final positions were formed, and how correction can occur. The framework treats accountability as a continuing political capacity because legitimacy can deteriorate when organizations retain the language of representation after the representative relationship itself has weakened.

Implications for pharmacy organizations and education

Pharmacy organizations that seek public-health influence require capacities that conventional professional representation may not automatically supply. Structured participation in medicines policy [6], the consequences of fragmented professional leadership [7], and evidence of organized pharmacy policy activity [8] suggest practical value in durable policy-analysis teams, relationship management, mechanisms for integrating practice intelligence, and transparent procedures for determining organizational positions. Transferable health-professional evidence further indicates that political participation is shaped by organizational conditions [16], while coalition scholarship implies that external coordination must be treated as an organizational competence rather than an occasional advocacy tactic [17].

Education should similarly move beyond teaching advocacy as persuasive communication alone. Student pharmacists have engaged directly with local policymaking through city-council participation, demonstrating one model of experiential exposure to public decision processes [32]. Public participation across healthcare education also provides a basis for incorporating public contributors into educational design, although the evidence remains heterogeneous [33].

A political-agency curriculum would therefore distinguish evidence communication, public representation, organizational governance, coalition work, agenda setting, conflict-of-interest analysis, and accountability. Learners should encounter disagreement and institutional constraints rather than practice only idealized advocacy scenarios. The educational aim is not to turn every pharmacist into a political specialist; it is to make the limits of individual action visible and to develop the capacity to recognize when collective, organizational, community, or policy-level action is required.

Research agenda

The framework generates empirical questions that cannot be answered by counting advocacy activities. Research should first distinguish voice, access, agenda position, decision consequence, and implementation consequence as separate outcomes. A professional statement, consultation invitation, committee seat, agenda item, and changed regulation represent different political states.

Second, configurational hypotheses should be tested. Where substantive pharmacy expertise is comparable, stronger organizational coordination may predict agenda access only when decision venues are institutionally open. Coalition breadth may improve political reach while reducing message coherence. Community representation may strengthen legitimacy without increasing influence where resource asymmetries remain extreme. Conversely, organizations with high political access may influence policy while failing representative tests.

Third, research should examine accountability dynamically. Studies could investigate whether organizations revise positions following constituency feedback, how disagreement is recorded, and when professional bodies cease to have a defensible basis for invoking community interests. Comparative work across jurisdictions could test whether statutory roles,

professional dominance, market structure, or consultation rules alter the value of collective capacities. Finally, political-agency research should examine counterfactuals. If comparable policy influence occurs without broad professional mobilization, institutional opportunity or elite access may explain more than collective capacity. If highly organized pharmacy coalitions repeatedly fail to affect agendas, the framework should identify which constraints dominate. If organizations achieve policy success while represented communities reject the outcome, political effectiveness and legitimacy have diverged. Such cases are theoretically informative rather than exceptions to be smoothed away.

Conclusion

Community pharmacy expertise can identify public-health problems, generate credible evidence, and reach populations that many health institutions struggle to serve. None of those attributes guarantees political influence. Influence requires capacities that sit partly outside individual professional competence: organization, representation, strategic voice, coalition building, access to consequential venues, and the ability to sustain an issue amid competing interests.

Collective political agency is also constrained by legitimacy. Pharmacy organizations cannot infer representative authority from professional expertise, public trust, organizational membership, or policy access alone. Claims made for communities require defensible relationships with those communities, including meaningful participation, visible disagreement, and opportunities for correction.

The strongest theoretical conclusion is therefore conditional. Pharmacy expertise is most likely to become legitimate public-health influence when organizations can combine credible knowledge with accountable community representation, durable organizational voice, coalition capacity, and access to agenda-setting processes. Where those conditions are absent, collective action may still be visible or professionally cohesive without becoming either politically consequential or legitimately representative.

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