Table 1: Examples of problems in drug access and pricing in the US and Canada

Problem	Examples
Inadequate access to drugs due to cost	In the US in 2014—after the full implementation of the ACA—an estimated 35 million non-elderly adults failed to fill a prescription in the previous year because of cost.[1]
	Among 11 high-income nations surveyed in 2014, the US (16.8%) and Canada (8.3%) had the highest rates of "cost-related non-adherence" (defined as skipping medication doses, or not having a prescription filled, over the last year as a result of cost) for adults aged 55 or older. All other nations, apart from Australia (6.8%), had rates below 5% (see Figure 2).[2]
Discriminatory cost-sharing	US private insurers often discourage high cost enrollees from choosing their plan by imposing high copayments for medications needed by ill individuals with high expenses. For instance, among 48 US health care plans, 12 placed all nucleoside reverse transcriptase inhibitors (used to treat HIV) into the highest cost-sharing tier, which imposed co-insurance 30% or greater.[3]
High drug prices for essential medicines	The US price of the CML drug imatinib—less than $30,000 per year when the drug was introduced in 2001—was repeatedly raised well after all R&D costs were recouped.[4] It now costs $146,000 per year,[5] compromising some patients' access to this life-saving drug,[4 6]
	Firms have boosted the prices of decades-old generic drugs such as pyrimethamine[7] and epinephrine[8], whose R&D outlays were long ago recouped.[9]
Payer restrictions on drug access	Some state Medicaid programs in the US restricted the use of newer hepatitis C medications due to cost, for instance requiring drug or alcohol abstinence—restrictions not present in clinical guidelines.[10]
	The province of Ontario only funds eculizumab, sofosbuvir and ledipasvir/sofosbuvir under its Exceptional Access Program because of the cost.[11]

ACA = Affordable Care Act.
R&D = research and development.
CML = chronic myelogenous leukemia.