Dutch population, on average, has changed plans each year. Moreover, accelerating consolidation of the health insurance market has restricted meaningful choice of insurance plan. Currently, four insurance conglomerates control about 90% of the Dutch health insurance market. Recent polls suggest public dissatisfaction with private insurers, with 65% of insured people reporting that they have low or very low levels of trust in private plans.

Fourth, notwithstanding the rhetoric of competition, the Netherlands still relies heavily on regulation. Indeed, the Dutch case shows that competitive systems that seek to escape supposedly centralized, bureaucratic control of medical care paradoxically require sophisticated regulation and government intervention in order to work. The government has not abandoned its traditional tools, including global budgets and constraints on prices and patient cost sharing. It sets fees for independent specialists and general practitioners and controls prices for most hospital services.[4] In 2010, for example, payments to specialists were reduced in response to budget overruns.

The Dutch Ministry of Health regularly engages in talks with the health insurance industry when there are complaints about rising premiums or copayments. Insurers must offer comprehensive coverage, and direct payments by patients amount to less than 10% of total medical care costs, among the lowest percentages in industrialized countries. The comprehensiveness of health insurance in the Netherlands provides a critical contrast to the Ryan Medicare plan, which would erode the U.S. government's contribution to the point that 65-year-old beneficiaries would pay about two thirds of medical costs themselves.

The myth that competition has been key to cost containment in the Netherlands has obscured a crucial reality. Health care systems in Europe, Canada, Japan, and beyond, all of which spend much less than the United States on medical services, rely on regulation of prices, coordinated payment, budgets, and in some cases limits on selected expensive medical technologies, to contain health care spending.[5] Systemwide regulation of spending, rather than competition among insurers, is the key to controlling health care costs. The Netherlands, after all, spent much less on medical care than the United States with virtually universal insurance coverage long before it began experimenting with managed competition in 2006.

The Dutch experience provides a cautionary tale about the place of private insurance competition in health care reform. The Dutch reforms have fallen far short of expectations — a reminder that policy intentions should not be confused with outcomes and that managed competition is hardly a panacea. The idea that the Dutch reforms provide a successful model for U.S. Medicare to emulate is bizarre. The Dutch case in fact underscores the pitfalls of the casual use (and misuse) of international experience in U.S. health care reform debates.[5] Before we learn *from* other countries' experiences with medical care, we first need to learn *about* them.

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Integrating Social Media into Emergency-Preparedness Efforts

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Despite blocked Internet service, new social media such as "speak-to-tweet" (which allows brief Twitter messages to be sent through a voice connection) were being used to improve communication about health and safety within the first few days of the 2011 Egyptian uprising, which had itself been organized by means of social media. After Haiti's 2010 earthquake, Ushahidi, an open-source Web platform that uses "crowd-sourced" information to support crisis management, linked health care providers requiring supplies to those who had them, and victims trapped