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Why Americans Are Going Abroad for Health Care

By Greg Lindsay

"This doesn't look like a hospital," says Ruben Toral, showing me around. "It feels more like a hotel or an upscale mall." After studying the gleaming lobby of Bumrungrad International for a minute or two, I'm inclined to agree. Americans in shorts recline across from Arab couples in flowing white dishdashas and black abayas, the latter accessorized with designer handbags and sunglasses. *We're in Bangkok in August*, when even the asphalt is overripe and malodorous, but the only scent inside is a faint whiff of espresso from the Starbucks in the corner.

Toral is responsible for luring that cosmopolitan clientele here, thousands of miles from home, for a knee replacement or a triple bypass or even just a checkup. Before he arrived in 2001 as Bumrungrad's marketing director, "we were a Thai hospital serving a Thai community," he says. "Now we're an international hospital that just happens to be in Thailand."

Toral himself just happens to be a dead ringer for George Clooney, and he tells his story in similarly seductive tones. He's still amazed, seven years later, that folks who have never set foot on a plane, let alone owned a passport, will log a 24-hour flight -- in coach! -- to put themselves in the care of a hospital whose name they can't even pronounce. Overseas patients have more than doubled on his watch, to 430,000 in 2006, generating the majority of the privately owned hospital's revenue. "It's the high-school-cafeteria person," Toral says. "The independent businessman, the doctor, the lawyer. They tell me, 'We did the math. We can't afford to pay $1,200 for insurance every month.' "

The phrase "medical tourism" was once used to describe early retirees jetting in to Bangkok or Bangalore to have a little work done before recuperating on the beach. That image doesn't jibe with the numbers today. As many as half a million Americans streamed abroad last year in search of affordable alternatives for hip replacements or prostate surgery. And they went not for the postsurgical tanning but for the savings: up to 90% off the going rates in the United States. They went because 47 million Americans lack insurance and can't pay for surgery to fix a bad back or clogged arteries. Or because they have insurance but can't begin to pay the soaring deductibles a major surgery entails. They're fleeing a system that is by far the most expensive in the world and growing more so by the hour, with diminishing returns in quality of care.

"Your options are paying $50,000 to $60,000 in the States or coming here and paying $8,000," says Toral, an American raised in North Carolina. "That's the difference between putting it on your credit card or going into bankruptcy."

A journey to Bumrungrad is hardly a descent into some third-world medical hell. It was arguably a world-class hospital even before it became a world-famous one (thanks in large part to a *60 Minutes* segment in 2005 orchestrated by Toral). Administrators have spent the past 15 years acquiring state-

of-the-art technology, adding beds, and wooing Thai doctors abroad to come home. Bumrungrad replaced its paper records seven years ago with a homegrown, all-digital system, an upgrade U.S. hospitals have struggled with for years, despite the assistance of giants like Cerner, Siemens, and General Electric. (Replacing prescription pads with tablet PCs is harder than you'd think, which might explain why last year Microsoft bought the company that designed Bumrungrad's software. Toral now works for Bumrungrad in an advisory role; he has struck out on his own with MedNet Asia, a software startup helping insurers handle paperwork.)

The hospital's outpatient clinic is more stylish than the bar at my five-star hotel. Instead of waitresses, some two dozen nurses tend to a polyglot mix of patients. Arrivals from Asia or the Middle East have separate floors to make them feel at home. There's an in-house travel agency offering visa extensions in case they suddenly need to stay. Modernizing late offered Bumrungrad a chance to leapfrog the competition and build the world's first truly global hospital.

But the Arabs sprawled across its lobby aren't oil sheikhs awaiting VIP treatment. They're humble civil servants, shipped in bulk from Riyadh and Dubai because Toral cut a deal with their governments to outsource their care to Bumrungrad. Medical tourism, Toral explains, is only the beginning. The next step is globalized medicine, in which millions of fully insured patients here in the United States are connected to hospitals in Bangkok, Singapore, and India. The patients will belong to Blue Cross Blue Shield, UnitedHealth Group, and maybe even *your* insurer. If Toral has his way, Bumrungrad's next heart- or knee- or brain-surgery patient will be you.

And if all this sounds a bit outlandish, brace yourself: The big insurers are already looking into it. "Once they understand the ramifications of this, you'll see the larger players start crafting policies that allow people to receive treatment overseas," Ori Karev, CEO of UnitedHealth International, the global arm of the UnitedHealth insurance conglomerate, told me. "I think you'll find most of us exploring this. We are a business at the end of the day."

Toral is an outsider twice over. Not only is he a foreigner in a Thai hospital, but he's neither doctor, operator, nor administrator. That may explain his near-total lack of empathy for the panic or anger those professionals would feel upon hearing his chilling vision of their future.

He only came to medicine after a stint consulting with Duke University's Center for Living, arriving in Thailand 15 years ago to set up "health and wellness" retirement villages for Westerners. That may explain his idea of health as a lifestyle choice, as opposed to a total war against death and disease. Health care, in his mind, is not necessarily a social compact or a universal right, but a quality product to be packaged and sold at a sensible price; he assumes patients are much savvier consumers than their doctors give them credit for.

Annual health-care spending in the United States has topped $2 trillion -- about half from private sources, half from public coffers -- to comprise a staggering 15% of GDP. That's almost double the average of other developed countries (9%) and more than half of global spending overall. That figure will only keep climbing, perhaps exponentially, as 80 million baby boomers, the so-called silver tsunami, begin to reach old age over the next 25 years. Their needs alone could keep every doctor from Boston to Bangalore gainfully employed for half a century, and a shocking percentage lacks insurance (or any real guarantee that Medicare will still be around when they reach qualifying age). As Toral puts it, a little indelicately: "God forbid you have a family of four, earning $50,000 a year. You are fucked."

Some economists have hailed our extreme health-care spending as the central pillar of a postglobalization economy built around services. In their view, hospitals and their support systems of doctors, administrators, and insurers have been, and will continue to be, the greatest creators of domestic jobs this century -- nearly 2 million so far -- especially in the Rust Belt and other areas hit hard by manufacturing's migrations. Yet when McKinsey consultants dug into health-care costs last year, a research team concluded there were no real incentives for either hospitals or consumers to

think hard about the ultimate price of treatment. Even adjusting for our higher per capita incomes, we're still overpaying by $477 billion a year, McKinsey concluded. At the same time, the United States ranks just 37th in the World Health Organization's list of the world's best health systems -- behind such medical hubs as Singapore and Costa Rica, and only 10 spots ahead of Thailand.

For someone such as Toral, the hypertrophied medical-industrial complex is just begging for a dose of disruptive innovation. He calls his vision the "Toyota-ization of health care," a metaphor so vast that it contains multiple readings, some fit for industry conferences and others he'll cop to only in confidence. In Toral's view, medical tourism as we know it is already giving way to "globalized health care." Hospital chains at home will buy, partner with, or even sell out to foreign rivals like Bumrungrad, creating worldwide networks of patients who will hopscotch across continents chasing the best care and costs. Insurers will leap at the chance to lower their own bills and offer members more options. And employers, dying to do the same, will induce employees to play ball by kicking back a share of the savings.

We'll learn to love surgery overseas, Toral insists, just as we came to prefer Toyota Camrys to Chevys. Nevermind that globalization of the auto industry gutted Detroit; it gave us cheaper, safer cars and helped lift Japan and South Korea into the ranks of first-world nations. Toral believes globalization will do the same for our health care (and quite possibly for India and Thailand). "Medicine has always been so locally driven that it can't think out of the box and ask, How does this globalize?" he complains while we watch translators, collectively fluent in two dozen languages, admit patients into Bumrungrad. "What it's looking at right now is the beginning of the beginning, which is individuals who are franchised, voting with their feet and heading out of the country."

The process will pick up speed as heavyweight for-profit U.S. hospital chains such as HCA ($26.8 billion in revenue), Tenet Healthcare ($8.8 billion), or HealthSouth ($1.7 billion) realize that hospitals such as Singapore's Parkway Group or India's Apollo chain aren't competitors so much as links in a global, offshore supply chain that can be bought and brought into the fold just as easily as a Toyota or GM plant. Medical tourism hubs will become different stops on the same assembly line: Brazil and South Africa for plastic surgery; Mexico and Hungary for dentistry; Costa Rica for a little of both; and Southeast Asia for the bodywork of heart surgery, organ transplants, and orthopedics. Patients needing new hips or hearts will be the first sent overseas by their doctors for the same reason medical tourists are headed there now: The procedures are safe, low margin, and high volume -- always the first things to go in any globalization scenario.

"There are going to be primary-care networks and emergency care, and then there are going to be surgical centers offshore," says Toral, laying it all out for me over dinner one night in Bangkok. "And the great thing is, [American companies] are going to own them!

"In order to ensure continuity of care," he goes on, "you'll never leave the system. What could be better than telling an American patient they're going overseas to an American-owned hospital? They're going to discover the same supply-chain advantages Toyota did when it created just-in-time manufacturing. We're going to have the same thing -- just-in-time *patients*. Hospitals are not going to spend any more money or any more time in the movement of that patient through the system than is necessary. They're going to get the patient in, get them on that global platform, and get them back. Now, how do they do that in a fast, efficient way where quality is kept, efficiency is gained, and prices don't go up? It's classic manufacturing and logistics."

Despite Toral's enthusiasm, it's unclear who will come out on top in a global wave of consolidation. There are precedents for U.S. companies owning hospitals abroad: Tenet went on a building and buying spree across Asia and Australia through the 1980s and early 1990s, until it sold off its holdings in the wake of a merger at home. (Toral's boss at Bumrungrad, group CEO Curtis Schroeder, was the Tenet exec who oversaw its 40% stake in the hospital back then.) And the trend continues with top-tier U.S. medical schools (and global brands) such as Harvard and Johns Hopkins cutting deals to open dozens of hospitals and teaching programs abroad. Harvard now has partners

in Mumbai, Seoul, Istanbul, Xinjiang, and Islamabad, to name a few, but its most ambitious creation by far is Dubai Healthcare City, a state-of-the-art complex staffed with the best equipment and doctors the ruling sheikh's money can buy. It's the brainchild of Dr. Robert Crone, former head of Harvard Medical International and now a managing director with the Huron Consulting Group in Chicago. "Institutions within the U.S. health-care system will have to think very creatively about how they can participate on a global basis," Crone told me. "The magic formula hasn't been developed yet."

The competition will be fierce. While I was in Thailand, the new CEO of the Bangkok Hospital (Bumrungrad's cross-town rival) mentioned he was interested in gaining a toehold in the States in order to guarantee a steady stream of patients: Give someone like him the sheikh of Dubai's money, and you might see sovereign wealth funds snatching up medical expertise much as China has been buying up our scrap metal.

Even if the roles of hunter and hunted have yet to be defined, there are clear winners and losers in Toral's scenario, which he sees unfolding over the next five years. The biggest losers by far would be American doctors -- especially cardiac and orthopedic surgeons -- who face the most damaging blow yet to their pride, public standing, and paychecks. In one fell swoop, they'd devolve from the rock stars of the OR to glorified mechanics, and they'd really only have themselves to blame. Overseas patients routinely return home raving about the personal attention shown by their Thai or Indian surgeons. Even before arriving, patients can trade phone calls and emails with doctors. (Nothing punctures the myth of American medical invincibility quite like the experience of having a doctor who actually speaks to you.)

Foremost among the winners would be the forward-thinking hospital groups and their shareholders -- in both hemispheres. They stand to profit enormously from the dismantling of an immense cost base on one side of the Pacific and its subsequent reconstitution as a streamlined profit center on the other. McKinsey tentatively estimates that maybe 10% to 20% of America's 39 million total hospital patients last year would have been well suited for transoceanic care. With a little back-of-the-envelope math that assumes those patients' surgeries would have cost $50,000 here, the top end of McKinsey's estimate yields an annual drain (or savings, depending on how you look at it) of $390 billion, more than the current GDP of Singapore. Also sitting pretty would be expat doctors, who would be free at last to return home from the States to practice world-class medicine, letting their patients come to them.

Yet another beneficiary would be the middlemen assisting in the care and feeding of globalization's newest nomads. Already, companies like IndUShealth have emerged as one-stop shops for curious employers, employees, and the self-employed (or unemployed) by offering a service that's part quality control, part travel agent -- all-inclusive package deals with airfare, hotels, a medical case manager, and even the cost of the care itself. "We offer an advantage in not being aligned with any hospitals," says IndUShealth CEO Rajesh Rao. "We tend to be more customer-centric."

Toral's entire road map, of course, is predicated on insurers' willingness to underwrite it, and there are plenty of signs they will. For starters, there's UnitedHealth's Karev, who took time out from speaking at one of Toral's medical-tourism conferences this past winter to share the establishment's thinking. "It's not just about the cost," he explains. "Quality is a major issue -- the quality of care, the documentation, the delivery." UnitedHealth is now working with Toral to offer plans listing Bumrungrad and other hubs as in-network for big-ticket items.

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There's also Aetna with its 37 million members, which last year acquired Goodhealth Worldwide, an overseas private insurer. CEO Ronald Williams said at the time that offshore medicine "will be an important emerging trend," and pondered, "How will it emerge, what are the opportunities, and how

do all the capabilities we have add value to it?" Since then, Aetna has green-lighted a pilot project for one customer to begin sending its employees abroad (if they so choose) for knee and hip replacements. "We're expecting everything to go well," says Aetna's national medical director, Charles Cutler.

But if insurers will be delighted to cut costs while adding more options, and employers will be equally pleased to see the same trickle down to them, the question remains: What about the patients?

Doctors in Thailand and India are arguably out-dueling their Western counterparts right now when it comes to better care. That may sound like sacrilege, but the bar is set lower than you think: More than 100,000 people die each year in U.S. hospitals from preventable errors alone, more than those who fall to AIDS, breast cancer, and car crashes combined. At Bangkok Hospital's three-year-old heart clinic -- really a hospital in its own right, treating some 15,000 outpatients a year -- stem-cell therapy is already part of the standard tool kit for treating battered hearts that might otherwise demand a transplant. "Most of the patients have been ill for a long time," the clinic's director, Dr. Kit Arom, told me in his art-strewn office. "By the time they come here, they are all but incapacitated. They are waiting for a transplant or waiting to die." After receiving stem-cell injections straight into cardiac muscle tissue -- a treatment too controversial to be offered yet in the United States -- most patients recovered enough to leave under their own power. On Arom's watch, the clinic has also retired open-heart surgery in favor of a new, decidedly less invasive approach using small incisions. Huron Consulting's Crone, having also seen the procedure performed in Bangalore, enthusiastically notes its "extremely low morbidity rate, and the patients are literally out of the hospital in a couple of days. It's this kind of innovation -- done with well-trained, U.S. board -- certified surgeons in a less oppressive environment -- that yields the potential for better health care than there is in the United States currently." Arom is more succinct: "It's a question of will."

Will patients embrace that perspective and agree to travel for their care? "They don't -- and we don't -- want to be in a situation where an insurer says, 'You have to go,' " says Victor Lazzaro, CEO of the packager BridgeHealth International and a former executive at Prudential. "The days of 'Mother may I?' medicine are over, and that's a good thing." One solution is to be up front with patients about the true cost of their treatment and offer to share the savings with them. In light of what it costs for a fresh set of knees in the States -- $45,000 and up for the uninsured -- and the huge discounts overseas, it's conceivable that patients might come out ahead if they let a Thai doctor install them. Of course, just because insurers won't use a stick doesn't necessarily mean the dangling carrot couldn't be considered coercion in its own right.

That's one lesson learned from the first would-be U.S. corporate pioneer in globalized medicine, one with plenty of arrows in its back. Blue Ridge Paper Products manufactures milk cartons at its original plant set in its namesake mountains; its VP of HR, 26-year veteran Darrell Douglas, discovered medical tourism the same way millions of Americans did -- by watching Toral's handiwork on *60 Minutes*.

"My ears perked up when I heard the prices," Douglas says, because the average annual health-care cost for Blue Ridge's 2,000 or so aging employees had doubled to $9,500 in just five years. "Every time we made a move to control costs, the provider community" -- read: doctors and hospitals -- "would make a countermove to protect their revenue stream." His interest was piqued enough to create a task force to study the options. One of its members was a then-60-year-old technician named Carl Garrett. In short order, Garrett nominated himself, Dick Cheney -- style, to be the company's first guinea pig, to travel to India to fix a worn rotator cuff and have a few gallstones removed. "He was our poster child," says Douglas, who has since left the company. "He took it upon himself to do the research, came to us, and said, 'I want to go to India. Will you allow me to go and share the savings with me if I do?' "

Douglas agreed, on the condition that Garrett sign a waiver absolving Blue Ridge of all responsibility. (Needless to say, New Delhi was considered "out of network.") IndUShealth was hired to find a

hospital and make arrangements; a plan was laid for Garrett to fly round-trip, stay in five-star hotels when he wasn't in the hospital, and himself receive 20% of the savings, up to $10,000. There was only one catch: Garrett's union, which called at the eleventh hour to squash the plan. Splitting the savings with Garrett constituted nonnegotiated compensation, the union contended. Garrett ultimately backed away from the controversy, choosing another surgeon here at home.

But the battle had been joined. The union president, Leo Gerard, sent a letter to every member of Congress declaring, in part, "The right to safe, secure, and dependable health care in one's own country should not be surrendered for any reason, certainly not to fatten the profit margins of corporate investors." A blog on the AFL-CIO Web site covered the debacle with the headline, "First Employers Sent Your Job Overseas. Guess What? You're Next."

"The problem with exporting people for health care is: Who goes?" says Stan Johnson, the union's Southeast director, his old-timer's drawl coming across loud and clear. "Is it voluntary now? Is it involuntary at some point? Do you end up sending your 80-year-old mother to India when she has never been sent outside of a 50-mile radius from home? You're going to put her on a plane and ship her to a hospital where they don't understand her language or her culture and where conditions may be suspect?"

I ask Johnson if he thought someone like Toral was being disingenuous, or merely deluded, when he claimed medical tourism could go a long way toward fixing health care. "Either or both," Johnson replies. "There are clearly people who see a significant opportunity from a monetary perspective. There are also people who think that competition is just the thing to fix the system. But I can without a doubt say they are not seeing the bigger picture."

Toral, naturally, sees something else at work in this kind of thinking. "Protectionism and slander," he declares, during a prescient rebuttal of Johnson's points, months before. "If you change the health-care equation, they are going to mobilize. *You want a Chinese doctor working on you? You want an Indian doctor working on you? Can you trust these people?* Of course, those doctors studied in your schools and speak your language, and they already mastered their medical system. Now they've mastered yours."

"They say, 'It's outsourcing, you're trying to drive [patients] out,' " Toral says mockingly. "Well, I'm not trying to drive them out; the American system is driving them out! My product is just as good as it was 5 or 10 years ago. The only thing that has changed is you. You're now unaffordable, unreachable, and you've got 47 million uninsured. So you do the math." At one particularly effusive moment during our dinner in Bangkok, Toral announces that a patient pipeline flowing from the United States to Bangkok or Singapore and back would galvanize practitioners and clue Americans in on the most intractable cost problem facing the industry today: the aggregate expenses of surgery, hospitalization, and administration. "Right there, you've saved maybe 40% of the total cost," he says, "and all of a sudden the pressure to overhaul the U.S. health-care industry is off you, because you've solved the most vexing problems out there."

> The American system is driving patients out; says Toral: "You're now **unaffordable, unreachable,** and you've got 47 *million* uninsured. So you do the math."

But can a free-market solution actually produce meaningful change, measured in terms of more care, better care, and lower costs? Toral is right to insist that the 24-hour flights, the Indian doctors, and the hospitals with unpronounceable names are red herrings; the real issue is whether these choices will eventually fix the system or simply extend it around the planet. But Johnson also is right: The recent history of health care is marked by elective improvements that soon enough hardened into the status quo. "Before this, there was 'first dollar' coverage," Johnson says, ticking them off. "Then there was the 'miracle' of HMOs, all of which were voluntary, and all of which quickly morphed into something quite less. It was the same thing with PPOs, and every new gimmick the health-care community can come up with." Will the promise of cash prizes go away, replaced by implied threats?

Will our choices simply disappear?

It's hard to imagine how the insurers -- operating in the same Hobbesian universe as the rest of us -- won't eventually winnow the choices down to having our care paid for in Bangkok or making us cover it if we opt to stay close to home. It's hard not to notice that their argument seems to boil down to, "Trust us."

The odds are good that the future of health care in this country will not be mapped by a grand visionary in government or some grim actuary buried at the bottom of an insurance conglomerate. It will more likely be the sum of many thousands of decisions made by well-meaning employers in places that look a lot like Myrtle Beach, South Carolina.

The morning I was in Washington, D.C., to meet UnitedHealth's Karev, I also had coffee with David Boucher, an early-rising bureaucratic do-gooder at Blue Cross Blue Shield. Boucher is an Army brat with inexhaustible energy and laserlike focus. He's no radical, however, having started at Blue Cross Blue Shield of South Carolina while still in grad school. He later left to run a few hospitals before returning in 1999 to oversee a BCBS call center. And yet, Boucher has done more than Karev and Toral combined to make global medicine a reality, at least for his 1.5 million members in the Palmetto State.

His Saul-on-the-road-to-Damascus moment came in the summer of 2006, when he and his wife elected to take their summer vacation at Bumrungrad. He had been tipped that it was the foreign hospital to see, and so they reserved an apartment at the Bumrungrad Hospitality Suites (normally reserved for recovering patients) and proceeded to take in the sights. By day, he toured the hospital's ER, ORs, and ICUs before dining at one of the hospital's various restaurants each evening. The eureka moment came as they were leaving, when his wife (evidently still on speaking terms) offered this non sequitur: "If I or anyone in my family needs an operation, we're coming here."

"Women make the decisions about health care in families," Boucher says over coffee. "If my wife felt comfortable about sending a loved one there, then I thought there might really be something to this." Once he was back in the office, he proposed launching a medical travel agency under the banner of BCBS, which compared to its hidebound siblings in other states is run like a pirate ship. "Thinking outside the state wasn't unusual for us but outside of the country was," he says.

His bosses gave him the go-ahead last winter to start Companion Global Healthcare, a one-stop shop for members heading overseas to make appointments, choose hospitals, and handle the travel arrangements. Bumrungrad was the first hospital to receive its seal of approval, a list that now includes Anadolu Medical Center in Istanbul (a Johns Hopkins partner), Costa Rica's Hospital Clínica Bíblica, and a trio of Parkway Group hospitals in Singapore. Anyone expecting an explosion of patients would have been disappointed; Companion pulled in only three in its first year. Boucher just shrugs. "We're neither surprised nor discouraged with the volume of patients," he says. "We're not even a year old at this point, and our primary markets are employers and brokers," two parties that need plenty of handholding and time to make decisions.

A month later, he invited me down to Myrtle Beach to meet one of his argonauts bound for Bumrungrad, a local civil servant named Mike Shelton. Meeting Shelton in an anonymous conference room, I was immediately struck by his sheer normalcy -- a roly-poly everymensch with a soft, almost tremulous voice, thinning brown hair, and glasses. He reminded me of no one so much as a less squirrelly Milton, the put-upon mascot of the movie *Office Space*. If his was the face of globalized medicine, then any one of us is liable to end up on a Bangkok operating table.

As it turned out, Shelton's motivation wasn't strictly personal. He happens to be the budget director for the City of Myrtle Beach, one of the key decision makers in whether the city's 800 employees, half as many dependents, and a burgeoning number of retirees will sign up with Boucher for similar trips. "Incorporating that into your plan is a bit complex," Shelton confesses, "because when you first say,

'Let's send you over to Thailand for medical care,' you don't quite get the warm and fuzzy reaction you'd like. It's more like, Do what?!"

But it's not as if he (or they) have much of a choice. Shelton's being squeezed by a new federal mandate, one that demands the city bring its costs in line with for-profit companies of comparable size. The acid irony of a public agency forced to scrap and scramble like a private enterprise isn't lost on him. But he hopes that by agreeing to outsource himself and his colleagues, they'll be able to keep major procedures such as spinal surgery and hip replacements in-network, rather than see them dumped from employees' plans completely.

During a fact-finding mission in February, Shelton took one for the team by scheduling his regular colonoscopy at Bumrungrad. Although routine, it's still (quite rightly) considered "invasive" surgery and priced accordingly. His last one cost $3,500, almost a third of which he paid out of pocket. This time, he'd been given a quote of $750 from Bumrungrad, a savings of nearly 80%. (The higher priced the procedure, obviously, the easier it is to absorb travel and other expenses. But this was a scouting trip, and Myrtle Beach picked up the tab.)

Staggering off a plane in Bangkok after a full day in the air, Shelton was met at the gate by the hospital's welcoming committee. They took his bags, checked him in for surgery, and drove him to the Bumrungrad Suites. He met his doctor the next morning, a young Thai who spoke excellent English. The ratio of nurses to patients, he noticed, was almost 1:1. Before he left, he had warned me, "If I start to feel too weird about it, I'm free to go," but his colonoscopy started early and went smoothly; he checked out the same afternoon.

Sitting comfortably back in his office in Myrtle Beach, Shelton says he wouldn't hesitate to return. Even for a $60,000 surgery? Sure, he said. What's more, savings on this scale would keep these surgeries available to his neediest employees, those who might have gritted their teeth through the pain rather than pay to go under the knife. In short, he's giving Bumrungrad his stamp of approval. Barring any unforeseen fallout from the city council, Myrtle Beach employees will soon find themselves at the forefront of globalized medicine.

I ask Shelton what he would say to the Stan Johnsons of the world, the ones who doubt the quality and intentions of a Bumrungrad or Apollo or Parkway. He pauses a minute before answering. "Let's face it; we tend to have the idea we're the best in the world. And maybe in some ways we are, and in some ways we're not. But certainly from what I've seen, I don't have the same impression that fellow had."

This is how it will begin -- with a crying need, with curiosity, and with the desire to see a place like Bumrungrad with one's own eyes. We'll make the trek once, or someone will make it for us, and word will spread that it's unlike anything we've seen at home ... it's better. And then we'll start to go. They're already leaving Myrtle Beach, and soon you'll be there too.

Greg Lindsay's book, Aerotropolis, *written with John Kasarda and based on his article for* Fast Company, *will be published in 2009 by Farrar, Strauss and Giroux.*
