It is rare that a scholarly work can be called soul-searching as well as wrenching, but *Blind Spot*, by physician-anthropologist Salmaan Keshavjee, is just such a book. Based on ethnographic research conducted after the collapse of the Soviet Union, in a remote and mountainous part of Central Asia at the margin of armed conflict, this is a haunting account of a goodwill effort to replace an inadequate public health system with a “sustainable” (and privatized) one. This new system is to be based, Keshavjee learns, on a post-Communist ideological framework even more impervious to course correction than the one preceding it. Lost in the battle between partisans of competing frameworks, one ascendant and one in the throes of collapse, are the poor and vulnerable and hungry who live in the Pamir Mountains, through which the storied Silk Road improbably winds.

For the reader who hasn’t heard of the Pamir Mountains or the region called Badakhshan, Salmaan Keshavjee offers rich detail. Its inhabitants, citizens of Tajikistan, might not find the word *rich* in any way apposite. When the young graduate student arrived at the tail end of a civil war, the lives of his hosts were precarious in every sense: the Soviet political system had collapsed, and the economy along with it. But beyond these dramatic events towers the immutable and cold rock face of the moun-
tains. Much of the region looks like moonscape—were moonscape to be blanketeted in snow.

In terms of health care and other basic social services, or even food and clothes, the poor of Badakhshan might as well have been lost on the moon. But this is also the story of those who are lost in other ways: the architects and implementers of programs and projects, blinded by ideologies cooked up in Geneva and Washington and other centers of soft (and not-so-soft) power. They assert that health care, to be sustainable, must be sold as a commodity even when and where the majority of its potential beneficiaries are unable to buy it. They have become the gatekeepers, sometimes reluctant, of a veritable “House of No.” The gates are barred to those unable to pay.

But who is convinced and who is really pressed (or press-ganged) into service? Take the example of a young Tajik dentist, Misha, who meets Keshavjee while seeking funding from an international nongovernmental organization in the hope of sparing some of his patients—the destitute, children, aging veterans, and others once protected, however feebly, by the Soviet health system—the closed-door fate that awaits them. The organization is one of several that have come to Tajikistan to address a humanitarian crisis provoked by the collapse of the Soviet Union, which triggered war and strife and privation.

Misha is portrayed as a sympathetic character, but he eventually gives in to the inevitability of the “reform” (a term used by aid officials and their advisors, apparently without irony) that rips even more holes in Tajikistan’s ragged safety net. Soon there are few patients in his waiting room or in any others. There is no viable alternative to privatization, Misha is forced to conclude.

Keshavjee’s account of the privatization of the dental clinic is piercing because the dentist comes to the same conclusion as the architects and apostles of neoliberal ideology. There aren’t many doors open to him, and even fewer for his patients. But how did the options before Misha, and others, come to be so powerfully constricted? Why are so many doors closed? How was the House of No erected, from what materials, and on what foundations?

Keshavjee’s book is an experience-near case study of the impact of “dogma over data” in a little-studied part of Central Asia. Here, the nine-
teenth-century Great Game of empire was followed by a century of Russian influence and then, suddenly, the collapse of the Soviet system, with attendant conflict and demographic decline. The extent of the contracture of the public services was of epic proportion. In a review of *Capital in the Twenty-First Century*, Thomas Piketty puts it like this: “At the global level, the most extensive privatization in recent decades, and indeed in the entire history of capital, obviously took place in the countries of the former Soviet bloc.”

But it’s not that the dissymmetries are new in Badakhshan, as Keshavjee’s history of the place, which is populated mostly by Ismaili Muslims, shows; the region’s inhabitants have known centuries of neglect or worse. In Badakhshan, the rapid erosion of public institutions, such as they were, fueled emerging social inequalities, themselves exacerbated by the rending of social safety nets. The Soviet health care system that preceded the collapse reached, if unevenly, into the highlands of Badakhshan. So did, surprisingly, the pensions and public works we associate with welfare states. But the quality of care was never very good, nor was a centralized system able to avoid shortages of medicines, perverse incentives, or demoralization among care providers. Claims of the effectiveness of this system prior to its erosion are suspect.

In the years of Keshavjee’s fieldwork, which began in 1995, this collapse was followed by the chaotic proliferation of what were termed, in developmentspeak, “civil society institutions” with very different and competing agendas. In the mid-1990s, disparities and asymmetries of all sorts—public-private, center-periphery, urban-rural, mountains-lowlands, practitioner-patient, foreign-local—abounded and were growing. Above all, and quite new, was the gulf between the tottering public health system and the well-resourced aid agencies and nongovernmental organizations (NGOs) new to the region.

As a graduate student, Keshavjee served as a consultant for one of the NGOs caught up in the irresistible logic of neoliberalism, or that part of it that claimed all health care should be marketed and sold as a commodity like any other in the market. But what if need isn’t matched by an ability to pay? This is the daily drama of the destitute sick, especially in rural areas; it’s why, across the world, they bang on the door of the House of No. They seek to be patients but are asked to be customers. It was during Keshavjee’s assessment of a revolving drug fund—some fraction of receipts
from the direct sale of pharmaceuticals would go to replenish the fund and the rest to finance primary health care—that one of his Tajik informants told him, ruefully, “You can’t sell medicines to starving people.” This was the working title of this book and stands as a concise assessment of both the promise of such projects and a demolition of the premise on which they rested.

Anthropology graduate students rely heavily on comments like these, a marker of their presence and proximity. *Blind Spot* is thus about translocal power, but not all of it is ethnographically visible: the dentist, a lucky professional in Badakhshan, is hardly powerful if he is obliged to beg Keshavjee, a student, for a pittance to keep his clinic open to those who need it most. Such personal narratives are woven together so artfully with the historical backdrop that dominates this account that it is difficult to put this book down. But even after reading the book twice and hearing iterations of it over the course of years, it’s hard for me to recollect many details about the Tajik characters in this account.

It’s not that these folks are there to serve up local color. It’s rather that Keshavjee’s strongest portrait is of his patrons and peers, those who funded the projects so openly designed less to improve health outcomes than to “change the mentality” of those seeking access to health services. Many of the new aid givers seem to speak in tongues, spouting a glossolalia replete with doublespeak about “privatization,” “user fees,” and new and “more efficient” ways of “managing” health care delivery. “Free trade” and “competition” are liberally invoked. Erstwhile patients become “clients,” “consumers,” or even “customers.”

*Blind Spot* is magisterial and scholarly, but the book is also humane and doleful and reflective: after all, Keshavjee was himself pulled into an effort, thus far fruitless, to sell essential medicines to the poor. He tells with sympathy the stories of hapless aid workers and care providers caught in the middle of a bitter struggle that has left them unable to serve the sick or to prevent unnecessary illness and suffering. It’s this wistful tone that packs the greatest punch. The study has a psychological depth (and reflexiveness) associated with his Harvard mentor, Arthur Kleinman, even as it brings to mind the work of fellow anthropologist James Ferguson and of sociologists like C. Wright Mills and Pierre Bourdieu.

It’s easy, especially looking back almost two decades later, to deride some development efforts as ineffectual or wasteful or cruel or ineffective.
or costly. Such derision is easy enough. It’s less easy, but not for lack of information, to parse carefully the reasons for failure (or success). And it’s downright difficult to identify reasons for failure in such a fraught enterprise and then to differentially weight them.

What’s stunning about this book is its suggestion that such an analytic effort, even if honest and painstaking, probably wouldn’t have made a difference, not in the short run. At least, such are the conclusions to be drawn from Keshavjee’s critical review of the Bamako Initiative upon which the Badakhshan project was based. The reader unfamiliar with health programs for the world’s poor may be unfamiliar with the terms of this debate, and might well ask, “Wait: isn’t Bamako in the West African country of Mali? Wouldn’t a program devised there be based on different kinds of data and dynamics than those encountered in the high reaches of the Pamir Mountains as the Soviet Union collapsed?”

Yes, Bamako is in Mali, but in truth, as Keshavjee shows, the influential Bamako Initiative, launched in 1987, was never based on much in the way of data. It was, rather, based on ideology and dogma of the neoliberal flavor.

Why didn’t it matter that these efforts, expected to fail, did fail, and early? Wasn’t there any “feedback loop” to correct or halt them, in either Badakhshan or Bamako? Keshavjee’s central thesis is that the proposed privatization of health care, termed “reform” across the former Soviet Union as in Africa and Latin America, not only engenders the curious doublespeak mentioned above but also creates, when handsomely funded, realms of *neoliberal programmatic blindness*. Keshavjee shows us how and why such logic becomes irresistible, in part because it is almost invisible, not to those on the receiving end nor to mediators like Misha, but rather to many of the rest of us, who fail to interrogate the models of “cost recovery” that have come to dominate discussions of public health and health care for the poor.

It’s not always clear how invisible such frameworks are to those convinced, as Margaret Thatcher put it, that “there is no alternative” (TINA) to an imperious logic that shapes programs and plans, limiting the choices not only of the world’s destitute sick but of those who might serve them. Are they confident ideologues, like Thatcher, or are they cowed into accepting mediocrity when faced with dramatic circumstances? Or do they go through cycles of confidence and uncertainty, as the architects and implementers of the neoliberal reforms outlined in *Blind Spot* seem to do?
To answer these questions, Keshavjee turns to the specifics of the Bamako Initiative. Bamako encouraged health officials of African nations, already heavily indebted to international financial institutions and private banks, to finance a slender package of health care for the poor by having the “consumer” pay for care when sick, in order to “recover costs” and thus finance health care through “community participation.” The dignity conferred by paying for one’s own (or one’s children’s) care would magically render such programs “sustainable.” Such responsible approaches would also cut down, suggested Bamako’s most ardent cheerleaders, on the sort of “frivolous spending” and “moral hazard” one encountered so often (or so you’d believe) in places like rural Mali. Such cost shifting to private payers—meaning patients and their families—would also decrease public expenditures in health care and “decentralize” care.

Why so many quotation marks? Could a Rosetta Stone of sorts help us decipher a language (developmentspeak or, in Orwellian terms, doublespeak) like this one? If there were key code breakers, they would surely include the Mont Pèlerin Society and the structural adjustment programs adopted in the 1980s by the World Bank and other institutions described in detail in Blind Spot. Let me first summarize Keshavjee’s description of the latter:

Bamako’s solution to the bank’s policy of structural adjustment—a policy that restricted public sector health spending—was to turn to financing and organizational mechanisms that promoted user fees to raise revenue and decentralization so that funds would be raised “close to the point of service” and not go into central government coffers. Viewed this way, it was the perfect “common sense” outcome. What was perhaps not obvious to most of those endorsing the proposal was that its principles were born from the mission of the Mont Pèlerin Society, the result of a decade of intense ideological construction. It was as if there was no alternative. (98)

And the health officials all signed on, as did the various United Nations agencies involved, from UNICEF to the World Health Organization. But there must have been many misgivings in Bamako. After all, the initiative contradicted, in so many ways, the 1978 Alma Ata declaration, whose slogan, “Health for all by the year 2000,” had been enthusiastically endorsed by the world’s health ministers: same signatories, more or less. But just as it’s difficult to find empirical studies to shore up claims that programs like
the revolving drug fund would be able to recover a substantial fraction of costs, so too is it hard to find many dissenting voices where it matters most. This is true even though it’s clear, as the editor of the *Lancet* suggested in 1988, that several claims made for Bamako were extravagant, even when data from the World Bank were considered: “Any cost recovery system would disqualify a considerable proportion of poor inhabitants of rural areas. A World Bank study in Kenya showed that any fee would exclude 40% of the population, and these are the people who most need access to the services. Charging the sick to pay for preventive services is also open to criticism.”

And this wasn’t just felt in Africa: Bamako metastasized. In 2000, in a book called *Dying for Growth*, physician-anthropologist Jim Yong Kim and colleagues offer a lucid and detailed report from urban Peru, written at about the time Keshavjee found himself entangled in the ostensibly anodyne revolving drug fund in Badakhshan:

According to several analysts, the success of these smaller, rural [clinics] at recovering costs owes more to the fact that they are residents’ only health-care alternative rather than to their true “affordability.” And even in these venues, Bamako Initiative funds were far from self-sustaining, in part because they suffered under a flood of inappropriate and expensive drug exports to Africa from pharmaceutical companies in industrialized countries. In the end then, decentralization of this kind has not proved sustainable; it has, however, accelerated the push toward private economies among people who can often ill afford them. This is apparently true even for public services that are supposed to be free, as underpaid government employees supplement their income through informal charges.

The reason for such widespread support for an unproven notion was not a temporary *folie à N*, with Africa’s health leaders suddenly espying epidemics of frivolous use of health services in the slums and villages of their home countries. Nor did they unanimously replace the previous slogan (“Health care for all by the year 2000”) with a new one (“Health care for some if they can pay for part of it when they’re sick, as we shrink our public budgets”). The officials signed on because adopting the Bamako plan was linked, if not always clearly so, to what the international financial institutions called “structural adjustment,” the linchpin of neoliberal policy. It was a sort of hidden conditionality, a “natural” part of the market
globalism that sought to commoditize health care and shrink social sector spending. Kim and his colleagues explain how it works:

The World Bank does not and cannot directly force poor-country governments to reduce spending in the public health sector. But, as a lending institution charged with ensuring repayment of debt, the Bank is in a position to offer guidance on how poor countries can best “streamline” their economies to meet their debt service obligations. As a result, in recent years, the World Bank has had an enormous impact on the health of impoverished populations. The design of privatization policies, and their manner of implementation, suggests that bettering poor people’s health outcomes is often incidental to their budget-cutting function.

For Kim and colleagues, the intentions of the architects of Bamako and other neoliberal strategies were less important than the health outcomes: “Whatever their ultimate intention, is it possible that privatization policies are ultimately beneficial to the health of the poor? If we base our answer on currently available data from both rich and poor countries, the answer seems to be no.”

But don’t expect either an apology or a retraction or a published erratum, since the TINA refrain works even better in retrospect: with conditionality of this sort, there was no alternative. Much of this story is a parable about the golden rule of neoliberalism (he who has the gold, rules). To link programs to the grant proposals that fund them is to unearth the doublespeak of dozens of bureaucracies in control of funds and thus of access to health care, such as it was and is. Blind Spot casts a light, sometimes harsh, on some of the most vexing problems of what is these days termed “global health,” and also on the relationship between citizen and state, between the poor and the powerful, and between shifting centers of power and periphery.

So, did the program in Badakhshan succeed or did it fail? Yes, replies Keshavjee. In Orwell’s usage, “double-speak” meant the ability to assert two contradictory claims as fact. High up in the Pamir Mountains, as in the fetid lowlands of Bamako, it was impossible not to feel a certain Orwellian chill. In Badakhshan, there was no need for any success beyond imposing the reform, just as had been the case in Bamako.

This uncoupling of interventions (“reform”) and assessment of their effectiveness in improving health, or at least in preventing catastrophe, is
often pathognomonic of dogma over data. We’ve met some of those who served up dogma to the hungry and the sick, but who cooked up the dogma? Keshavjee introduces us to some of the people he believes were injured by neoliberalism but also tries to identify the mechanisms of the injury, and why some are spared. He also, and sometimes brashly, makes claims about the etiology of such injury. If one Rosetta Stone is the World Bank’s structural adjustment programs, what of the other code or key—the role of the Mont Pèlerin Society?

If there’s one smoke-filled room, it’s to be found, argues Keshavjee, in an obscure Swiss resort town called Mont Pèlerin. There, in 1947, a veritable who’s who of neoliberalism convened to lay out a plan for, well, global domination.

Such statements can sound sweeping, even ex cathedra, if not buttressed by ethnographic research, and here Keshavjee has helped fill the void between assertion and documentation. Many discussions of neoliberal policies and “the Washington Consensus” have an almost paranoid ring to them, and Keshavjee echoes it simply by quoting those among his informants who struggle directly for survival amid the anomie and confusion and disorder of economic and social collapse. But his close reading is not only of the documents laying out the revolving drug fund and health reform project, but also of the historical record. This allows us to follow him from the smoke-filled hovels of craggy Pamir to those smoke-filled rooms in which policies are hammered out and messages hammered home until they seem to be “just common sense.”

Mont Pèlerin is home to some of those smoke-filled rooms. The effort to achieve hegemony (“There is no alternative”) required, Keshavjee claims, a decades-long campaign designed less to promote a specific school of economics or any other type of analysis, and more to promote a specific political and social program. This book offers an analysis of how that scaffolding was erected and what it propped up in specific places and times. Keshavjee names names, bringing into view the “organic intellectuals” (and their approach was at times Gramscian) of neoliberalism and how they worked to promote this program and ensure its inevitability.

In a recent review, Manfred Steger observes that “market globalism is without question the dominant ideology of our time.” He contrasts it to two competing forms, “justice globalism” and, from the Right, “religious
globalism.” Papal Francis and many other social justice advocates from liberation theology might dispute this typology. In his first major exhortation, issued in November 2013, Pope Francis attacked neoliberalism specifically and related “ideologies which defend the absolute autonomy of marketplace . . . reject[ing] the rights of states . . . to exercise any form of control.” But Steger’s observation about how neoliberalism gets in our minds is worth noting: “Market globalism has become what some social theorists call a ‘strong discourse’—one that is notoriously difficult to resist and repel because it has on its side powerful social forces that have already pre-selected what counts as ‘real’ and, therefore, shape the world accordingly. The constant repetition and public recitation of market globalism’s core claims and slogans have the capacity to produce what they name. As more neoliberal policies are engaged, the claims of market globalism become even more firmly planted in the public mind.”

The aspirations of the Mont Pèlerin Society were not, in any sense, unambitious (then again, nor was “Health for all by the year 2000”). These aspirations touted “free markets” as a panacea for the world’s economic and political ills; the health problems of the poor were not a ranking concern. Reporting from the Pamir Mountains, Keshavjee recounts how health care expenditures can often lead to the ruin of people already living on the edge, at the close of war and upheaval. This is nothing new, as studies from around the world, in poor countries and in rich ones, show that catastrophic health care expenditures are the number one cause knocking people from poverty into destitution. To link such unhappy tales to the deliberations of those who argued that markets alone should determine what sort of welfare programs should exist is a perilous enough task. It is more so when those deliberations take place far away (and long ago, in terms of medical history). But it is not a long road, Keshavjee shows us, from the mountains of Badakhshan to a resort town on the shores of Switzerland’s Lake Leman.

If health outcomes and social protection are, in the words of Jim Yong Kim and colleagues, “often incidental” to the design and financing of health systems, it must be, as in Tajikistan, that such reforms have other goals. And so they did, from privatization to the reduction of public budgets and staff. What were the “transfer mechanisms” by which neoliberal programmatic blind spots were overlooked when convenient?
Keshavjee suggests that this role was played largely by international NGOs, new players who showed up in places like Tajikistan as the Soviet Union was becoming the former Soviet Union, and also seasoned USAID contractors. In development speak, these, along with humanitarian groups, are the citizenry of “civil society.” But there are NGOs and NGOs, and it is the funders, argues Keshavjee, who distorted the agendas of institutions such as those willing to implement the revolving drug fund described in Blind Spot. Funding for the transfer mechanism, at least in Central Asia, came less from the World Bank and more from the champion of a “reform” that looked a lot like the strictures of the Bamako Initiative, complete with a revolving drug fund. And yes, they were glossed as “RDFs.” The U.S. Agency for International Development was among the largest.

This book is also a cultural history of the rise of the twentieth-century transnational institutions, public and private, that shaped and were shaped by neoliberal ideologies. It casts a bright light on the institutions mediating these relationships and webs of power. These include the too rarely examined roles played by NGOs in replicating, wittingly or no, a social order that promises enduring disparities as patients are transformed into consumers—or, as often as not, nonconsumers—of health care and other social services. And thus documents as anodyne as grant proposals become part of what Thomas Piketty has termed “the apparatus of justification” of social and economic inequality. But Keshavjee, as noted, does not denigrate those who staff these bureaucracies; still less does he denigrate their motives. If anything, the anthropologist-physician has extended to them a hermeneutic of generosity and expunged some of their inculpatory (and exculpatory) correspondence. The staff of many, perhaps most, international nongovernmental and humanitarian organizations, including the one that sponsored Keshavjee’s work, would flinch to hear themselves described as key sleeper agents for neoliberal policies. But he explains, better than anyone yet has, how these changing institutions relate to shifting development agendas and to public health and medicine in settings as far flung as Mali and the mountains of Badakhshan. This metastasis continues in settings across the world.

Five points are worth underlining in closing this foreword to Keshavjee’s thoughtful and troubling book. The first is that it’s difficult (perhaps almost impossible) to achieve equity of access to decent health care when neoliberal
paradigms underpin care delivery. There are many ways to state this assertion, and it’s important to try them all on for size. Amartya Sen and Jean Drèze, in their recent book about India—a country that has known fast economic growth but little improvement in the welfare of the poorest third or so of the population—note that building a strong *publicly* financed health system is critical to success, even if there are other, nonpublic insurers in the mix. In the absence of fine-meshed public safety nets, quality services are by definition reserved for those who can pay for them. Holes in these nets—even the contraction of the notion of shared goods like social protection—is surely one of “the causes of the causes” of both ill health and the impoverishment it so often causes or complicates. As in post-Soviet Tajikistan, whenever and wherever social services are seen as commodities rather than rights, chances are that catastrophic health expenditures will serve as a brake on progress in the fight against poverty and for health.

A second point is that there’s little sign we’re nearing the end of a neoliberal period in global health. The problem lies not only in past policies, much excoriated by Keshavjee, of the Reagan and Thatcher era; nor does it lie in programs specific to the empire they sought to bring down. The neoliberal period is the moment we’re in, right now, as study after study reveals growing inequalities between and within nations. From Tajikistan to Britain, safety nets are being stretched or rent or brought so low that they can no longer break the fall of those facing both poverty and serious illness. The problem is especially acute in the United States: as *Blind Spot* goes to press, a recession with roots in poorly regulated finance and a retreat from the state’s responsibilities in social protection have led to similar reversals of fortune in a country responsible for many of the development policies Keshavjee unearthed on the other side of the world. Americans can also ask if and how and when NGOs and even churches (or other religious institutions) have served, wittingly or unwittingly, as “transfer mechanisms” for a heaping helping of economic and social pain that is visible in foreclosed houses, shuttered businesses, and the decay of cities built around manufacturing.

Third, there is ample room for resistance to the crass commodification of health and health care in the emerging arena of *global health equity*. There are a number of examples from the past few years, almost a decade after Keshavjee’s fieldwork. Some would argue (at least I would) that global health equity is only now coming into being and that the role of
neoliberal paradigms in this endeavor has yet to be determined. Take the example of user fees or the import of expensive pharmaceuticals, another problem mentioned by Jim Yong Kim and colleagues in their critique of Bamako. This was published in 2000, well before the establishment of the President’s Emergency Plan for AIDS Relief (PEPFAR) or the Global Fund to Fight AIDS, Tuberculosis, and Malaria. These are among the largest efforts or institutions in the new architecture of global health equity, and two of the reasons that ten million people living with both AIDS and poverty are now receiving treatment with antiretroviral therapy, or ART. If there were user fees associated with access to ART through PEPFAR or the Global Fund, many of the millions living with HIV would have died from it; most of the drugs were manufactured by the generic drug industry. There are many problems of the sort described in Blind Spot—for example, the ongoing weakening of public sector institutions or high overheads to contractors—but the success of PEPFAR and the Global Fund has sparked another recent turn toward ambition and equity.

Fourth, the “minimalists” and the “optimalists” continue to clash in professional debates about health care delivery. Selling medicines to starving people may not be wholly discredited in such circles, and the ideas that underpinned fantasies about revolving drug funds may be alive and well, but, twenty-five years after Bamako, universalism is emerging from its coma. Many health officials in the countries signatory to Bamako are now grappling with the challenge of providing health care services to all their citizens. The chief debate going forward seems to be between the optimalists who seek to build “universal health care” systems (whether with a strictly public care system or with a national health service that does not rule out private insurance) and those who advocate “targeting” the poor with a more minimalist package of services. In reviewing experience in India, the world’s laggard in equitable access to care and protection from catastrophic illness, Jean Drèze and Amartya Sen summarize one part of a brisk global debate: “A health system based on targeted insurance subsidies is very unlikely to meet basic norms of equity in health care, as four different sources of inequality reinforce each other: exclusion errors associated with the targeting process; screening of potential clients by insurance companies; the obstacles (powerlessness, low education, social discrimination, among others) poor people face in using the health insurance
Fifth and finally, things change. The ethnographic research informing this study was conducted in a time of rapid, indeed catastrophic, change. Such research is necessarily ethnographic and attuned to social change. Sometimes this is cataclysmic: war, natural disasters, and rapid social collapse reveal a lot about “the shock doctrine” in part because such extremity prompts spectators and those touched directly to ask why so many had to die. In Tajikistan, in the wake of civil war and food shortages, there was also a collapse of systems of meaning, of ways of making sense of the citizens’ relationship not only to the state but also to each other. The commonweal, the sense of shared opportunities and misfortunes that bind us together—after all, what is “pooled risk” if not sharing?—is often one of the first casualties of hard-core neoliberalism. And things continue to change. More than a decade later, Keshavjee has learned that his old friend Misha is now in Badakhshan’s government. Jim Yong Kim is president of the World Bank.

It’s hard to point to empirical studies documenting the corrosive effects of neoliberalism in health care and education. But when the diagnosis is soaring inequality, what is the actionable agenda? Keshavjee hints at a response to this question at the end of this book. He may be ironic, but there’s no cynicism here. Keshavjee shares the Enlightenment belief that it is possible to understand what’s happening, to “measure outcomes” of great import to those who face punishing risk to health and well-being. Such outcomes, including the socially corrosive ones, will not be measured without bringing the mechanisms of social process into relief. They will not be gauged without understanding casuistry or seeking to understand how neoliberalism works itself into the lives and bodies of those who feel most keenly the impact of policies and programs like the ones examined in this book. Blind Spot acknowledges that claims of causality are difficult to make. But this is not because such effects don’t ensue; it’s rather that they are complex and far reaching and require, for any full measure of noxious effect, a commitment to the sort of research and reflection that Salmaan Keshavjee offers here. This is the work of an engaged and critical anthropology for which we all have cause to be grateful.