

Before and After Scenarios

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World in Transition — Before and After

How Daily Life Changes Through the Transition

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Introduction

This document presents side-by-side scenarios and operational flowcharts showing what changes between the current world and a Transitioned one. The form is deliberate: every NOW path is the actual sequence of operations a real person currently navigates; every AFTER path is the sequence that becomes possible when specific structural conditions are met; the WHAT CHANGES column names those structural conditions explicitly, so readers can see the engine of transformation and not just its results.

Why this form. Most writing about social transformation operates at the level of principles and structures. That's necessary work, but it's hard for readers to act on. This document does something different: it shows what Tuesday morning looks like for an actual person in each system. Most people cannot reason about *capitalism versus post-capitalism* in the abstract. Almost everyone can reason about *what happens when their child needs surgery*, or *what happens when a hospital needs to be built in their town*, or *what happens when a talented young person wants to become a doctor*.

What each detailed scenario contains: - **NOW:** the operational path through the current system, with friction-points named - **WHAT CHANGES:** the structural enabling-conditions that make the AFTER possible - **AFTER:** the streamlined operational path - **Follow the resources:** where time, money, and human energy actually go in each version - **Real-world precedents:** places where the AFTER (or a meaningful component of it) already operates, with outcome data - **Honest caveats:** what changes in culture alongside structure; what failure modes remain; what tradeoffs are real

Who this is for. Readers who can absorb operational specifics even before agreeing with the underlying value-system. The form is designed so that *the inefficiency-cost of the current system becomes visible before the value-argument is made*. Many readers who would resist a values-based argument can absorb a measurement-based one. Once they see that the NOW path is 20 steps and the AFTER path is 9, the measurement is itself an argument — and the steps eliminated are almost entirely the ones that don't deliver care.

How to read. Section A gives short scenarios at different registers (individual, family, community, national, international) for quick scanning or social sharing. Section B is the fully worked-out healthcare flowchart, demonstrating the form’s full depth. Section C gives detailed flowcharts for seven additional domains. Section D is notes on form, contribution, and next steps.

Section A — Short Before-and-After Scenarios

Each scenario below presents a concrete situation in roughly equal NOW and AFTER paragraphs. The register varies from individual through international scale.

1. The aspiring doctor (*individual*)

NOW. A talented young person with the intelligence, drive, and care to become a doctor cannot afford medical school. Takes loans totaling \$200,000–\$400,000. Graduates with crushing debt. Specialty choice constrained by ability to service debt; primary care underserved because it pays less. Practices for years to recover financially before the work itself becomes the center of the practice. The vocation is distorted by the economics from the first day of training.

AFTER. The same young person takes entrance exams to medical school, passes, completes training without financial barrier. Chooses specialty based on aptitude and demonstrated need in the community. Begins practicing immediately as a contribution to society rather than as debt-servicing labor. The vocation matches the calling. Society receives the addition of a doctor whose practice is shaped entirely by medicine.

2. The family with a sick child (*family*)

NOW. A child develops a serious illness. The family has insurance through one parent’s employer. Insurance denies coverage for the specialized treatment the doctors recommend. The family launches a GoFundMe. They go into bankruptcy. One parent leaves work to provide caregiving; the family loses their insurance with the job loss. The child receives some treatment, sometimes the wrong kind, sometimes none. The family is destroyed by a combination of grief and financial ruin that was never necessary.

AFTER. The same illness. The family takes the child to the hospital. Diagnosis. Treatment. The family stays whole. Recovery, or — if recovery is not possible — the family is held together to grieve, rather than torn apart while trying to grieve.

3. The community that needs a hospital (*community*)

NOW. A region needs a hospital. Materials, land, qualified personnel, and architectural plans all exist or can be acquired. No level of government will allocate the funds; no private investor will build because operating margins are unattractive in that demographic. The

hospital is not built. People drive ninety minutes for emergency care. Some die en route. Births happen in cars.

AFTER. The same region. Materials, land, qualified personnel, plans. The hospital gets built because building hospitals where people need them is what we do. Doors open. People receive care.

4. The aspiring artist (*individual*)

NOW. A talented young artist cannot afford training. Works service jobs to fund creative work. Art-making is constrained to evenings and weekends. Most don't make it. The talent is wasted at the social level; the artist is exhausted at the personal level. The few who succeed often do so through luck, family wealth, or extreme self-exploitation. Most art that gets made and distributed is the art that is commercially defensible — a narrow slice of what humans can actually create.

AFTER. The same young artist takes entrance exams to the school appropriate to their craft (music, visual art, theater, writing, film). Trains under masters. Develops their voice. Their work circulates because circulation isn't gated by marketability. Society receives the full breadth of art human creativity actually produces, not just the commercially defensible fraction.

5. The pandemic response (*national/international*)

NOW. A virus emerges. Public health response is delayed by political contestation. Vaccine development outpaces vaccine distribution because patent-protected manufacturing limits supply. Wealthy countries hoard vaccines; poor countries wait. Lockdowns destroy small businesses while large corporations consolidate market share. Trust in public-health institutions is damaged for a generation. Excess deaths run into the millions.

AFTER. The same virus. Public-health response activates immediately because the public-health infrastructure isn't subordinate to political contestation. Vaccine development and distribution proceed in parallel; manufacturing capacity is treated as a public good and scaled accordingly. Vaccines reach poor countries faster than rich ones, because the goal is global suppression and the math actually works that way. Lockdowns where needed include economic support sufficient to maintain businesses and families. Trust in public-health institutions is strengthened rather than eroded.

6. The climate-adaptation infrastructure (*national*)

NOW. A coastal city needs seawalls, drainage upgrades, heat-resilient housing, food-system redundancy. Funds aren't available because climate adaptation has no profit center. Some piecemeal work happens after each major flood or fire. Costs accumulate as crisis-response rather than preparation. Lives are lost. Properties are destroyed. Insurance markets collapse, and the federal government becomes the insurer of last resort at massive cost.

AFTER. The same coastal city. Adaptation infrastructure is built as standing public investment. The work happens once, properly, before the crises. The economic case is obvious: \$1 invested in adaptation prevents approximately \$6 in disaster response (this is established by FEMA data already). Lives are saved. Properties are preserved.

7. The refugee crisis (*international*)

NOW. War or climate disaster creates millions of displaced people. Receiving countries treat refugees as economic burden and political liability. Camps fill. People wait in indefinite limbo for years. Children grow up undocumented. Tensions rise in host communities. Far-right political movements harvest the fear and inflame it. Some refugees die at sea or on land trying to reach safety.

AFTER. The same displacement. A receiving cooperation-network activates: housing capacity is identified across willing receiving regions, language support and integration services are pre-positioned, refugees are matched to communities where their skills are needed and welcomed. Integration happens at human pace. Refugees become contributors to receiving societies (as they have, empirically — refugees historically have higher entrepreneurship rates than native populations). Far-right scapegoating loses its raw material.

8. The local development decision (*community*)

NOW. A development proposal arrives in a town. The developer has lobbyists, lawyers, and political contributions. Local residents have a few hours after work to read the planning documents (if they're posted at all). Public comment periods are technically open but practically inaccessible. The decision is made by the people with the capacity to engage. Residents discover what happened after the fact.

AFTER. The same proposal. A deliberative process activates: a representative sample of residents is convened, given paid time off work to participate, provided with technical support to understand the proposal, and given access to experts of their own choosing. The decision is made by the community, with informed input. The form has been tested in Ireland, Iceland, France, British Columbia, and many other citizen-assembly experiments — it works.

9. The end-of-life passage (*family/individual*)

NOW. A loved one is diagnosed with a terminal illness. Treatment options exist but insurance authorization is uncertain. Family members take on caregiving, often leaving jobs and losing their own healthcare. Medical bankruptcies accumulate. The final months are dominated by financial fear as much as by grief. Hospice access varies by zip code and insurer. Some die receiving care; many die fighting for it.

AFTER. The same diagnosis. Treatment options are available; the doctors and the family decide on the appropriate path based on medical and human considerations. Caregiving is supported (paid leave for family members, professional home-support available). Hospice

is universally accessible. The final time is dominated by what it should be: presence, love, the work of saying goodbye, the integration of a life. The grief is grief — not financial ruin laid over grief.

10. The talented hardworking person in any field (*individual, general form*)

NOW. A talented hardworking person has everything needed to learn and master a profession (any: scientist, engineer, teacher, craftsperson, healer) — except the money. The training is gated by financial barrier. The vocation is delayed or abandoned. The contribution that person would have made is never made. Society loses the contribution. The person carries the unlive d vocation through their life.

AFTER. The same person takes entrance exams, passes, gets the training, makes the contribution. The vocation matches the life. Society receives what only that person could give.

Section B — Detailed Flowchart: Healthcare

This is the worked example demonstrating the document's full form. The other domains in Section C follow this structure in lighter treatment.

NOW: A hospital is needed in a community

Operational path through the current US system. Each step represents a real sequence of operations a real person navigates.

1. **Funds have to be found** before anything can happen. If they cannot be found at any level of government and no investor is willing, *the story ends here*. People drive ninety minutes for emergency care. Some die en route.
2. Funds are eventually found (assume the optimistic case).
3. **Infighting over how the funds are used** — who controls the project, which firms get contracts, which architectural style, where exactly to site it, whose political district gets the credit. Months to years of delay.
4. Hospital is eventually built.
5. **A hierarchy is established.** Hospital is registered as a corporate entity. Board appointed. Administration hired.
6. **Hierarchy hires doctors, nurses, technicians, and other staff.** Hiring is competitive with other hospitals; salaries are constrained by what the hospital can afford given its revenue model; recruitment costs add to overhead.
7. **Hierarchy discusses how to make the hospital profitable.** *This step alone takes substantial executive time and shapes every subsequent decision.*
8. **Negotiation and contracts with insurers and (increasingly) private equity firms.** These external entities dictate operating parameters: which treatments will be reimbursed, at what rates, with what authorization processes.

9. **Significant resources are spent on marketing** the hospital to insured patients in the catchment area.
10. Hospital opens. Doors are physically unlocked.
11. Patients come in.
12. **FIRST PRIORITY BEFORE TREATMENT: establish how they will pay.** Front-desk staff process insurance verification. Uninsured patients are routed differently (often to emergency department only, with massive billing to follow). *The medical process is gated by the financial process.*
13. Doctors propose diagnostic procedures.
14. **Financial department consults insurer** to authorize or deny each diagnostic.
15. **Financial department dictates to the doctor** which diagnostic procedures will actually be run. *Doctors with medical-school debt and contractual obligations to the hospital have limited ability to push back.*
16. Diagnosis is reached — or not. Sometimes the right diagnostic was denied and the diagnosis is wrong or incomplete.
17. Treatment options identified by the medical team.
18. Doctors consult financial department and insurers.
19. **Financial department and insurers dictate to doctors** which treatments will be administered.
20. Treatment proceeds. Outcomes are sometimes worse than they should have been because of the financial gating. Bills arrive months later, sometimes far exceeding what patients expected even with “good insurance.”

The NOW path requires ~20 operational steps. Roughly half of them are not medical.

WHAT CHANGES: The architectural enabling-conditions

These are not all-at-once requirements. They are the necessary conditions for the AFTER path; partial implementations achieve partial benefits.

- **Medical training fully publicly funded.** No student debt for medical, nursing, or technical training. This produces a large reservoir of healthcare professionals motivated by vocation rather than debt-service.
- **Healthcare provision decoupled from insurance.** Care is funded as public infrastructure, not transacted as private commerce. The financial-authorization layer between doctor and patient is eliminated.
- **Hospital construction and operation funded as public infrastructure** — like roads, like fire departments, like libraries. Where need exists, the institution exists. This is not “government healthcare” in the constrained sense some readers will fear; it is healthcare-as-public-utility, which can take many organizational forms (cooperative, public, regional, federal).
- **Standard professional compensation set at societally-respected levels.** Doctors and nurses earn well — not as much as the most-compensated US

physicians under the current system, but well enough to attract talent. Compensation is set societally, not negotiated individually under conditions of structural debt.

- **No profit-motive entity in the care-delivery chain.** Private equity is structurally excluded from hospital ownership. Insurance companies, if they continue to exist for non-essential coverage, do not gate basic healthcare.
- **The New World Web** (Transition-framework infrastructure): a publicly accessible information system that allows hospitals to announce openings, professionals to identify positions, and communities to identify needs without requiring corporate marketing budgets to mediate the matching.
- **Cultural shift:** medicine understood as care, not as commerce. *This is the slowest of the changes, but it is downstream of the structural changes more than upstream. People operating in a system without commercial gating do not, in practice, continue to treat medicine commercially.*

AFTER: A hospital is needed in a community

1. Need is identified at the community level (population, geography, current access gaps).
2. Hospital construction proceeds as standing public infrastructure investment.
3. Hospital is built. Materials, land, plans, and qualified construction workers are all available because none of these are individually gated by profit considerations.
4. Announcement on the New World Web that the hospital is open and seeking staff.
5. Medical professionals — drawn from the large reservoir made possible by debt-free training — come to staff the hospital. Many move from places with surplus capacity to places with need.
6. All systems and equipment are tested. The new hospital community of providers holds a few meetings to get organized. Work rosters are agreed upon.
7. Doors open. Patients come.
8. Doctors diagnose patients.
9. Doctors treat patients. Treatment decisions are made by doctors and patients in consultation, based on medical considerations.

The AFTER path requires ~9 operational steps. Compression ratio: ~2.2×. None of the steps eliminated are medical.

Follow the resources

Where the money goes in NOW. Approximately 25–30% of US healthcare expenditure goes to administrative overhead, versus ~10–15% in single-payer systems. For a hospital with \$500M annual revenue, that's \$75–100M per year that doesn't reach care. Major line items: insurance-authorization staff; billing-and-collection departments; marketing budgets; executive compensation; private-equity profit extraction (where present); legal costs for coverage disputes; debt service. Clinician time spent on documentation-for-

billing is estimated at one to two hours per hour of patient contact — roughly half the clinical workforce's time is administrative.

Where the money goes in AFTER. Approximately 85–90% of healthcare expenditure flows to direct care: clinician compensation, equipment, medications, facility operations, training, research. Administrative overhead drops to ~10–15% (the level Canada, the UK, France, and other developed-country comparators already achieve).

Compression in monetary terms. For the US system, the difference between current ~30% administrative overhead and benchmark ~12% is roughly \$700 billion per year — enough to provide universal coverage without any new spending, if reallocated.

Real-world precedents (the AFTER, in whole or in part, already exists)

- **Cuba.** Medical training is publicly funded; no student debt; large reservoir of doctors (8.2 per 1,000 population, highest in the world). Cuban doctors serve in over sixty countries.
- **United Kingdom (NHS).** Care funded as public infrastructure; doctors do not gate diagnosis or treatment on financial authorization at the point of care; outcome data comparable to or better than the US on most metrics at roughly half the per-capita expenditure.
- **France.** Hybrid system with universal coverage; outcomes among the best in the world; expenditure ~11% of GDP versus US ~17%.
- **Veterans Health Administration (USA).** Non-profit medical system operating inside the US; outcome data comparable to or better than private US medical care on most measures; cost per capita lower. *An existence-proof inside the US that the AFTER path can operate even within a broader market system.*
- **Costa Rica.** Universal healthcare; life expectancy higher than the US at a fraction of per-capita spending.

Honest caveats

- **The AFTER does not eliminate all healthcare problems.** Wait times for non-urgent care can be longer in single-payer systems, though emergency and urgent care are typically faster. Resource allocation decisions still have to be made; they just get made differently.
- **The cultural shift is real but lags structural shift.** Even after decoupling, some practitioners will operate in commercial-gating habits learned from the prior system. This adjusts over a generation.
- **Innovation funding requires explicit attention.** Some critics argue that profit-motive innovation in pharmaceuticals or medical technology slows in non-commercial systems. The empirical record is mixed: many of the most important medical innovations have come from publicly funded research (NIH, university labs) rather than from for-profit pharma R&D. The AFTER assumes adequate public investment in medical research.

- **Specialization can be over- or under-supplied.** Single-payer systems sometimes underpay specialists relative to generalists, causing shortages in specific fields. The compensation structure needs to be designed carefully to match supply to need.
 - **Transition costs are real.** The path from NOW to AFTER includes shutting down or repurposing significant private infrastructure. Insurance industry workforce displacement alone is roughly 2 million US jobs. The transition has to include support for those workers, retraining where appropriate, and time-phased rather than overnight implementation.
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Section C — Detailed Flowcharts for Seven Additional Domains

Each domain below follows the same NOW → WHAT CHANGES → AFTER structure as Section B, with shorter treatment.

C.1 Education (becoming any professional)

NOW (*path for a person who wants to become an artist, scientist, engineer, doctor, teacher, or any other trained vocation*): 1. Person identifies a vocation. 2. Person learns the cost of training: K-12 quality varies by zip-code property tax base; higher education ranges from \$30,000 to \$400,000+ depending on field and institution. 3. Person applies; if accepted, takes loans. If not financially feasible, defers, often permanently. 4. Person attends, accrues debt, often works simultaneously, often experiences mental health strain. 5. Person graduates, enters job market constrained by debt-service requirement. 6. Career choices distorted by debt: high-paying specialties chosen over high-need specialties; corporate paths chosen over service paths; geographic mobility constrained. 7. Person services debt for 10–30 years. Many never reach the work they originally trained for.

WHAT CHANGES. Education at every level — K-12, vocational, undergraduate, professional, lifelong learning — funded as public infrastructure. Admission to programs by demonstrated readiness and need, not financial means. Living stipends adequate to support study without simultaneous employment. Faculty compensated to teach rather than incentivized to maximize research grants. Cultural respect for vocational and skilled trades equivalent to academic paths.

AFTER: 1. Person identifies a vocation. 2. Person prepares for entrance exams or portfolio review appropriate to the field. 3. Person passes the threshold of demonstrated readiness. 4. Person attends, with living support. 5. Person trains, mentored by masters, alongside peers. 6. Person enters the field as a contributor, choosing the work that matches their gifts and society's needs. 7. The contribution unfolds across the working life.

Precedents. Germany's free higher education and respected vocational track (the *Ausbildung* dual system). Nordic countries (Denmark, Finland, Norway, Sweden) with free higher education and living stipends. Cuba's universal free education through doctoral level. Argentina's free public universities. The US's land-grant universities and the GI Bill — *evidence that the AFTER existed partially within the US in the mid-20th century.*

Honest caveat. Free education does not automatically produce equality of opportunity if K-12 quality varies wildly by neighborhood, as it does in the US. The reform has to include K-12 baseline equality, or the AFTER scenario reproduces the existing inequalities at the entry threshold.

C.2 Housing

NOW: 1. Person needs a place to live. 2. Person earns income from employment; ~30–60% goes to housing. 3. Renters face annual rent increases, threats of eviction, displacement through gentrification, instability. 4. Aspiring homeowners face down-payment barriers, mortgage qualification challenges, predatory lending in poorly regulated markets. 5. Multigenerational wealth gaps determine ability to buy; renters subsidize landlord wealth-building through monthly payments that never accrue equity. 6. Housing instability is the single largest predictor of negative life outcomes across health, education, mental wellbeing, family stability. 7. Homelessness exists alongside vacant investment properties.

WHAT CHANGES. Housing recognized as basic infrastructure, not investment vehicle. Mixed model: substantial public housing of high quality; cooperative ownership models; cost-controlled rentals; private ownership preserved but stripped of speculative-investment role. Land-value taxation discouraging vacant property accumulation. Investment capital redirected from housing speculation to productive investment.

AFTER: 1. Person needs a place to live. 2. Person accesses housing through whichever path matches their situation: public housing (no shame, high quality), cooperative (community ownership), rental (cost-controlled), private ownership (preserved but not speculative). 3. Housing is stable: no eviction without cause, no displacement through speculation. 4. The cost of housing is a small fraction of income; remaining resources go to other life activities. 5. Homelessness, where it appears, is treated as a crisis to be solved, not a feature of the market.

Precedents. Vienna's social housing (60% of residents live in publicly built or supported housing; quality is high and includes mixed-income buildings). Singapore's HDB system (over 80% of citizens live in government-built housing they own). Finland's Housing First program (reduced homelessness by ~50% by providing housing without preconditions). Mondragón Cooperative Corporation includes housing cooperatives among its institutions.

Honest caveat. Housing-as-investment is deeply embedded in middle-class wealth-building in the US. The transition must address how existing homeowners' equity is treated — abrupt change would be destabilizing. Time-phased approaches work better.

C.3 Food production and distribution

NOW: 1. Industrial agriculture optimized for monoculture, dependent on fossil-fuel inputs, fragile to climate shocks. 2. Subsidies flow to large agribusinesses; small farmers squeezed. 3. Rural economies hollow out as farms consolidate. 4. Food production is high; distribution is broken: paradoxical hunger amid surplus, food deserts in inner cities, food

swamps in low-income areas. 5. Diet-related disease is epidemic: obesity, type-2 diabetes, hypertension, heart disease. 6. Approximately 30–40% of food is wasted in the supply chain. 7. Climate consequences of industrial agriculture (soil degradation, water use, greenhouse gas emissions) accumulate as externalities not paid by producers.

WHAT CHANGES. Regional food systems with diversity and redundancy. Small- and mid-scale farms supported as essential infrastructure. Direct distribution networks between growers and eaters. Free or low-cost distribution where need exists. Subsidies redirected from large agribusiness to regenerative agriculture practices.

AFTER: 1. Food production is regional, diverse, and resilient to climate disruption. 2. Farmers practicing regenerative agriculture are supported as essential workers. 3. Distribution networks connect production to consumption efficiently; food reaches people who need it because that is what the system is designed to do. 4. Diet-related disease declines as access to nutritious food becomes universal. 5. Food waste drops because surplus is redistributed rather than discarded. 6. Agricultural practices regenerate rather than degrade soil and water systems.

Precedents. Cuba's organopónicos (urban agriculture; developed during the Special Period crisis, became permanent infrastructure). Detroit's urban agriculture renaissance. La Via Campesina (international peasant movement linking smallholder farmers across continents). Brazil's Zero Hunger program (substantially reduced food insecurity through coordinated production and distribution policy). France's law against supermarket food waste (requires donation rather than disposal).

Honest caveat. Regional food systems require regional climates that support diverse production. Some regions will continue to depend on imports for some foods. The AFTER reduces but does not eliminate global food trade.

C.4 Conflict resolution and justice

NOW: 1. A harm occurs (interpersonal, property, or other). 2. Police are called (where present) or a civil action is initiated. 3. The process becomes adversarial: prosecution vs. defense, plaintiff vs. defendant. 4. Plea bargains resolve ~95% of criminal cases without trial; the bargaining power is asymmetric (prosecutors hold leverage; public defenders are over-extended). 5. Civil cases favor parties with resources for legal representation. 6. Outcomes: incarceration (for crimes), monetary judgments (for civil cases), often little restoration for the harmed party. 7. Recidivism rates are high because the system addresses neither the conditions that led to the harm nor the harm itself. 8. Communities that experience high incarceration rates are further damaged by the loss of community members.

WHAT CHANGES. Restorative justice protocols available alongside or instead of adversarial justice. Community courts with authority over appropriate categories of cases. Investment in conditions that prevent harm: housing, mental health care, addiction treatment, economic security. Police role redefined: armed response reserved for cases

where it is actually needed; other responses (mental health crisis, neighbor disputes, traffic enforcement) handled by appropriate specialists.

AFTER: 1. A harm occurs. 2. The response is appropriate to the harm: restorative process for many cases, mental health response where relevant, community mediation where appropriate, armed response only where genuinely needed. 3. The harmed party is centered in the process: their experience is heard, their needs are addressed, restoration is the goal where possible. 4. The person who caused harm is held accountable in a form that includes understanding what was done, repairing what can be repaired, and addressing the conditions in them that contributed to the harm. 5. Recidivism rates drop because the system addresses both the harm and the conditions. 6. Incarceration becomes a last resort for cases where it is genuinely needed for public safety.

Precedents. Norway's prison system (focus on rehabilitation; recidivism rates roughly half of US). New Zealand's incorporation of Maori restorative practices into the criminal justice system. Various US municipal pilots of restorative justice in schools (reducing suspensions and improving outcomes). Portugal's drug decriminalization (drug-related deaths and HIV infections both dropped substantially).

Honest caveat. Restorative justice does not work for every case. Crimes where the person who caused harm shows no remorse, refuses participation, or poses ongoing threat still require coercive measures. The AFTER reduces but does not eliminate the need for incarceration in some cases.

C.5 Civic decision-making

NOW: 1. A policy question arises (local, regional, national, international). 2. Elected representatives bring constituent inputs filtered through campaign-donor priorities and lobbying influence. 3. Decision-making processes favor parties with resources to engage: lobbyists, lawyers, communications professionals, sustained presence in committee proceedings. 4. Most citizens learn what was decided after the fact, often through partisan media that shapes their understanding. 5. Trust in democratic institutions erodes as it becomes clear that influence is unequally distributed. 6. Polarization increases because shared deliberation becomes rare.

WHAT CHANGES. Campaign finance reform substantially reduces the role of money in elections. Citizen assemblies — representative samples of residents convened with paid participation and expert support — bring direct deliberation into the decision-making process for specified categories of issues. Deliberative processes complement electoral representation, not replace it. Transparency in legislative and regulatory processes is structural, not optional.

AFTER: 1. A policy question arises. 2. Representatives bring it to the appropriate forum, which may include citizen assembly for issues that benefit from direct citizen deliberation. 3. Citizens — selected as a representative sample, with paid time and expert support — engage the question seriously. 4. The decision reflects informed citizen deliberation, with

electoral representatives implementing. 5. Trust in democratic institutions strengthens because the process is genuinely participatory.

Precedents. Ireland's citizen assembly on abortion (led to constitutional reform with strong public support). Iceland's post-2008-crisis citizen assembly on constitutional reform. France's Citizens' Convention on Climate. British Columbia's Citizens' Assembly on Electoral Reform. Multiple Canadian, Australian, and European examples of working citizen assemblies on contested issues.

Honest caveat. Citizen assemblies work well for specific bounded questions. They are less suited to ongoing operational governance (budgets, day-to-day administration). The AFTER includes citizen assemblies as one tool among several, not as a replacement for representative government.

C.6 Science and research funding

NOW: 1. Researcher identifies a question worth investigating. 2. Researcher writes grant applications. Funding agencies favor low-risk, near-term applied research over high-risk fundamental work. 3. Researcher spends 30–50% of working time on grant-writing and administration. 4. Publish-or-perish dynamics drive emphasis on quantity of publications over depth. 5. Some research is locked behind paywalls; replication studies are underfunded; negative results often unpublished, leading to wasted effort by other researchers. 6. Commercial pressures shape what gets studied; lines of inquiry without near-term commercial application are neglected.

WHAT CHANGES. Stable baseline funding for researchers at qualified institutions, freeing them from grant-cycle pressure. Funding for high-risk fundamental research as a category. Open-access publication as standard. Funded replication studies. Negative results valued and published. Commercial application is one path among several rather than the dominant criterion.

AFTER: 1. Researcher identifies a question. 2. Researcher pursues it with support that allows for the depth and timeframe the question requires. 3. Results — positive, negative, or null — are published in open-access venues. 4. Other researchers can build on the work; replication is funded; cumulative knowledge advances faster. 5. Commercial applications develop from the research as one outcome among several; fundamental knowledge is valued as its own outcome.

Precedents. Howard Hughes Medical Institute's investigator model (long-term funding to individuals rather than projects). The German Max Planck Society. Bell Labs in its heyday (long-term fundamental research that produced the transistor, the laser, information theory, and many other foundational developments). Open-access publishing initiatives (PLOS, arXiv, bioRxiv).

Honest caveat. Stable funding can produce complacency in some institutions. Periodic evaluation and accountability are needed even within a stable-funding model. The AFTER

assumes that evaluation focuses on research quality and contribution rather than narrow metrics like grant dollars or publication counts.

C.7 End-of-life care

NOW: 1. A person receives a terminal diagnosis. 2. The family attempts to navigate insurance, treatment options, financial implications simultaneously with the emotional reality. 3. Treatment is sought; insurance authorizes or denies; appeals may be filed. 4. Family members frequently leave employment to provide caregiving; often lose their own healthcare in the process. 5. Medical bankruptcies accumulate during the period of dying. 6. Hospice access varies by zip code, insurer, and financial means. 7. The final months are dominated by financial fear and bureaucratic struggle as much as by grief, love, and the work of saying goodbye. 8. The bereaved are left to grieve while also dealing with the financial aftermath, which often includes inherited debt or destroyed savings.

WHAT CHANGES. Healthcare decoupled from insurance (per Section B). Paid family caregiving leave universally available. Professional home-support available regardless of ability to pay. Hospice and palliative care universally accessible. Cultural support for the work of dying — recognition that this is sacred work, that it deserves time and presence, that grief is not a financial transaction.

AFTER: 1. A person receives a terminal diagnosis. 2. The medical team, the patient, and the family decide on the appropriate path based on medical and human considerations. 3. Treatment is provided where appropriate; palliative care is provided where treatment is not the right path; hospice is available when dying becomes the focus. 4. Family caregivers receive paid leave and professional support. 5. The final time is dominated by presence, love, the work of saying goodbye, the integration of a life. The grief is grief. 6. After death, the family grieves without financial ruin layered on top.

Precedents. Most of Western Europe operates substantial parts of the AFTER through their healthcare systems and family leave policies. Costa Rica. Japan's combination of universal healthcare and family-care support. Hospice movements worldwide, originally pioneered by Dame Cicely Saunders in the UK, now developed in many forms. *Most readers in the US who have experienced end-of-life care in countries with these systems describe a qualitatively different experience.*

Honest caveat. No system makes dying easy. The AFTER does not remove grief; it removes the conditions that compound grief unnecessarily. The transition does not eliminate the deep human work of saying goodbye; it allows that work to be the focus.

Section D — Notes on Form, Contribution, and Next Steps

On the form. This document establishes a structure that can scale: NOW (operational path through the current system, with friction-points named) → WHAT CHANGES (architectural enabling-conditions) → AFTER (operational path through the transitioned

system) → Follow the resources (where time, money, energy actually go) → Real-world precedents (the AFTER, in whole or part, somewhere already) → Honest caveats (what changes alongside structure, what failure modes remain, what tradeoffs are real). Each scenario can be expanded or compressed depending on use: tweet-sized for social, paragraph-sized for short publication, full-page for detailed treatment, illustrated for accessibility, animated for video. The same content reaches different audiences and attention spans without rewriting from scratch.

On contribution. Once the form is established, this becomes a participatory document. Contributors with domain expertise — practitioners, researchers, organizers, people with lived experience — can submit before-and-after pairs from their own fields using the template. The collection grows as the framework grows. Some scenarios that should be added by people who know them better than we do: childcare and early-education provision; mental-health-crisis response; energy generation and distribution; transportation systems and the daily commute; immigration processes; veterans' care; criminal-record sealing and reentry support; small-business formation in a non-extractive economy; cross-border cooperation on shared environmental challenges.

On honesty. The form is designed to keep this document credible. Every AFTER is anchored in real-world precedents where they exist. Every scenario includes honest caveats about what doesn't change, what still goes wrong, and what tradeoffs are real. This is not utopian writing; it is concrete extrapolation from what already exists, in some form, somewhere. The discipline of including the caveats is what allows the rest of the document to be persuasive — readers who feel themselves being sold something will reject the whole; readers who feel themselves being shown something will engage even with conclusions they initially resist.

On translation. This document is in English. The form should translate readily into other languages and into the cultural specifics of other countries. The NOW paths will differ — the friction-points in the Indian healthcare system are not the friction-points in the German healthcare system are not the friction-points in the Brazilian healthcare system. The WHAT CHANGES columns will draw on different traditions and practical experiences. The AFTER paths may converge or diverge depending on local culture and values. The form is robust; the content is local.

Next steps for this draft.

1. *Review and revision by Barak.* This v0.1 is a working draft. Areas where the framing or content needs adjustment, additions, deletions, or reframing should be identified.
2. *Initial publication subset.* Maybe five to seven scenarios released first to test the form with readers, gather feedback, and refine before expanding.
3. *Visual design.* The flowcharts in particular benefit from visual rendering — the contrast between a twenty-step NOW and a nine-step AFTER lands more powerfully visually than in prose.

4. *Translation pipeline.* For multilingual dissemination per the Transition framework's commitments, this document's form needs to be portable into the framework's other language layers (the Rosetta Stone work in progress).
5. *Web presentation.* When the World in Transition website is ready, this material lives there with appropriate navigation: by domain, by register (individual / family / community / national / international), by depth (short scenarios / detailed flowcharts).

— End of v0.1.

This document is part of the Transition framework's bridge between the academic-publication layer and the public-facing-accessibility layer. It complements the foundational frameworks (The Cure, the Roadmap, the Daily-Spine declaration, the field-theory of selfhood, the Mathematical Unified Theory of Oligarchic Capture) by making their implications concrete at the level of daily life. The principle is simple: when readers can see what changes for them and the people they love, the framework stops being abstract and starts being a question of when and how, not whether.