Is There a Space for Diversity in the Italian Welfare System? The Case of DEI in Organ Donation and Transplantation and Minority Communities

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1 Introduction

Debating about diversity around 30 years from its inception and spreading in the so-called Westernized world has a whole different meaning. The days of Roosevelt Thomas (Thomas, 1990) scientifically explaining the need to exit the spiral of affirmative action and plunging into the management of diversity seem very faraway in time, despite the fact that Italy was probably one of the later countries to embrace any approach to diversity.

Not only has the issue of diversity, and its application, to different contexts changed over the years, but it now differs in its denomination and in its span of engagement.

In this chapter, we address Diversity, Equity, and Inclusion (DEI), foraying into an underlying concept of social justice. The context is that of the Italian welfare system, encompassing social services, healthcare-related services, either in the public or private sector, and in the middle ground populated by third sector organizations. We'll then reference a specific case of an Italian public health institution's engagement to improve equity and inclusio by presenting research on the organ donation and transplantation process in the context of the Italian multicultural society. Perhaps not surprisingly, the conclusion is one of diversity responsiveness and diversity competence as a matter of reciprocal recognition and social engagement.

2 A Perspective on the Organizations of the Welfare System

Healthcare services (at least the national healthcare service), social services, and the third sector area in general are difficult to frame from the perspective of the organization development literature. On the one hand, they are not directly motivated by profit, as they do not belong to the productive world; on the other hand, they are not guided by a set of values as ideally nonprofit activities are. We can probably say that they have a mission statement and that day-to-day management, especially in the last 30 years in Italy, is oriented toward controlling resources on the one hand and achieving measurable goals on the other. This makes these organizations somewhat "tied down" from the point of view of the innovative momentum they could have; however, it leaves open some spaces for movement that, however small, make a difference. Unfortunately, innovation is left to the initiative of individuals and often to their goodwill, a situation that makes

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them feel isolated but increases the leadership capacity of individuals and ultimately of the organizations they represent. Public social and healthcare services and nonprofit organizations often operate from a perspective of social justice, understanding of others, and acceptance, so their ability to manage internal diversity might seem obvious, but this is not always the case (Castiglioni, 2009).

In times of virtual communication for most organizations and corporations, we have realized the physical space for relationship is still a necessary condition for most interactions in the context of care. So far, telemedicine has not yet supplanted visits nor have social service interventions become virtual, at least in this part of the world. So ideally, either there should be a highly developed communication competence in intercultural terms or there should be an interest in this regard. The recognition of each other in moral terms tends to happen in a physical shared space, such as a hospital, for instance. But the same could be said for a school or an intervention in a Roma camp. Why do we use the term "moral"? Insofar as we recognize the relational meaning inspiring actions of "the other," we qualify subjects of specific actions as moral people (Barbera, 2023). Thus, space situated interaction, given certain conditions, can generate a specific human quality, which is that of imagining a more just collective future (Barca & Luongo, 2020). It is a capacity which needs to be nurtured, fed, and supported.

3 Diversity, Equity, and Inclusion

While the most common denomination of any approach to diversity is Diversity, Equity, and Inclusion (DEI), we must say in the Italian Welfare system, the issue of Diversity has never really become meaningful, while Equity and Inclusion have a much larger space, both in the public discourse and in current actions (e.g., political and public policies, disciplinary research and literature, advocacy and some behaviors).

3.1 Diversity

The impetus for the spread of diversity management in the United States, where the focused approach started, was the dissemination of a report prepared by the federal Department of Labor in 1987 that, over the next decade, turned American labor organizations upside down: Workforce 2000. The report, after a careful examination of the US economy, outlined some key trends of the 1990s, which turned out to be consistent with what happened in that decade: about 85% of the workforce would be Black, along with 61% of women entering the workforce. Only 15% of the employed population would be White men. Already by the early 1990s, White males born in the United States represented a numerical minority, and the proportion of this group's workforce was set to decline, thanks in part to much higher birth rates in the Black population. The report also still sees immigrants as a major determinant of population and labor force growth; as a result, it would have had a more diverse composition within it, as women, people of color, and immigrants would have accounted for more than five-sixths of the increase in the labor force between the late 1980s and the 2000s. This was the case. In this regard, the report lays out some guidelines about the efforts to be made by government and the labor market to adjust institutions (e.g., a reform of pensions and maternity protection laws); school education, which must ensure a truly competitive, multicultural education and bring to college graduation students who, in the past, would have stopped at high school graduation; corporate training, to increase, for example, the dynamism of a working class composed of increasingly older individuals, who need lifelong training that accustoms them to greater flexibility, as well as increasing the specific skills of such a workforce. The document adds, finally, that if the situation had not changed since the report's release, the United States would have lost the opportunity to have a future and would have seen an increase in minority unemployment, crime, and welfare dependency. If racism, sexism, and other forms of discrimination constitute an obstacle to the

productivity of women, ethnic minorities, people with disabilities, and in general LGBTQI, this is to the detriment of the entire community, as well as businesses and organizations, and the country would lose international competitiveness. For these reasons, an increasing number of companies began to see a resource in diversity training programs. The focus was that of shifting, also for obvious economic reasons, from an acceptance of affirmative action, which aimed at an ideal of equal opportunity based on moral values, to a realization that the situation should be addressed for the very survival of organizations (Castiglioni, 2009).

In Italy, such a report has never been done, but if we collect data from different sources and consequent estimates and appeals, we would necessarily draw very similar conclusions from those in the United States. The trend is not only Italian; rather, Italy records an extreme situation in the hive of Western industrialized countries. The last available Italian census in 2022, says there are 5.6 people over 65 for every child under 6 years old. For the first time, also in the United Kingdom, there are more retirees than children, and, by the middle of this century the average Japanese citizen will be 55 years old. The first consequence is a shrinking labor force. Starting in 2009, according to a World Bank study, the European labor force has begun to decline, and more people will retire than can be replaced. So, the retirement age will be postponed. If we look at the group aged 80 and over, their share was almost 6% in 2020 (it was 3.4% in 2001). As far as people aged 65 and over in the total population, Italy (23%), Greece, Finland Portugal, Germany, and Bulgaria (all 22%) had the highest shares, while Ireland (14%) and Luxembourg (15%) had the lowest. Over the period 2001–2020 an increase in the share of persons aged 65 and over could be observed in all EU Member States, from the highest increase in Finland (+7 p.p.) to the lowest observed in Luxembourg (+1 p.p.) (Eurostat report 2021 edition). It is well known that women live longer on average than men, which also means that there will be more women in the labor force.

Finally, the only way to maintain a developing economy is to attract labor from abroad, so it will be migrants and their descendants who will keep the economies of many countries afloat. A report from the health communication agency ADNkronos (2024) indicates, for example, that in Italy, as of the last quarter of 2023, there has been a significant increase of both nonnative physicians and nurses. About 5.5% of the nurses are non-Italian nationals. Among the most represented countries are Romania, Poland, Bulgaria, and Albania in Europe; Peru, Colombia, and Brazil in Latin America; Tunisia in Africa; and India in Asia. We add to these the 11,000 nurses who came during the COVID-19 pandemic and the 1800 from Ukraine, who came after the Russian invasion of their country. The actual need is in fact much higher. Foreign professional nurses work in Italy not only in the wards of hospitals but also in hospices and nursing homes; it is precisely from private clinics, nursing homes, and institutions for the elderly and disabled non-self-sufficient that the greatest number of requests for employment come. It has been estimated that, for the nursing sector, the turnover of interim agencies is of several hundreds of million euros per year, calculated on a need for 40,000 employees. There are about a dozen employment agencies active in this labor market, and six of these provide exclusively foreign staff. In exchange for carrying out the paperwork for equivalency of qualifications and finding housing, the agencies also require 20–25% of the worker's monthly gross salary.

In 2019, before the COVID-19 public health emergency, the number of medical doctors coming from abroad was 21,000, out of which 15,800 originated from non-European countries. Of these, 75% work in private structures used through regional agreements by the national health public system, as professionals from beyond the EU are not entitled to access public hiring contests. However, during the 2020 emergency, a decree of the President of the Republic (DL n.18, March 17, 2020) enabled these physicians to enter public hospitals on a temporary basis, so far extended until December 31, 2025. It is a de facto pass which is likely to last for a long time in the future. In some regions, particularly in Southern areas, these foreign physicians have

even become the referent family doctors (e.g., general practitioners).

Other areas of social work have been affected by these precarious dynamics of the world of work. Foreigners, especially foreign women, trained as cultural-linguistic mediators are yet another example of needed professionals who are not formally recognized by the system. This is also true for elderly people caregivers, who mostly come from non-EU countries and who represent a business of 1% of the internal gross product. In such a panorama, talking about awareness and eventually valorization of diversity becomes mandatory.

Why is it that, in such an increasingly multicultural scenario, there seems to be a scarce interest in the acquisition of diversity competence, especially on communication skills and on the valuing of different values and approaches?

Services are changing, the third sector is changing, with distorted roles, unstable careers, increasingly frequent shifts between public and private, with commissioned or project-based work, and with outsourcing of many interventions. Such impressive change over the past two decades does not seem to be matched by rapid responsiveness on the part of this system's stakeholders; low salaries, poor training, and aging of sector workers dampen enthusiasm and creativity as well as often being a barrier to change. In the health sector, the greatest investment is understandably in healthcare training and its continuous updation and in necessary and costly training related to the digitization of processes, but still too little is done with respect to the doctor-patient relationship and even less with respect to relational and organizational dynamics. Nevertheless, an inclusive work environment seems to be the only recipe for creatively surviving these changes and learning to take advantage of them.

3.2 Inclusion and Equity

Among the three terms of DEI, *Inclusion* is the one that has really taken root in the Italian welfare and educational system. The target of inclusion are users, frequently people with different abilities,[1] or migrants (Lombardy Regional Council, law 25/22, November 29, 2022). This is true for the public system and for all the compartments of the third sector, where private not-for-profit social enterprise collaborates with the public system[2] (Lecce et al., 2021). However, "inclusion" has a much wider meaning, and the one mostly accredited in this sector is very close to the one of "equity."

Another way to talk about inclusion is to refer to talent enhancement, which cannot be separated from a deep acceptance of people for who they are. Having to change one's appearance or lying about one's tastes or choices in order to accommodate to a work environment is a behavior that we have all enacted at one time or another, as if it were normal or due. This hardly has made us loyal, innovative, or committed employees; on the contrary, recognition of our potential along with acceptance of who we are has often made our real abilities blossom. This aspect is being supported in some areas of the different professions, but not in others.

[1] This is now reflected in laws, i.e., that of the Lombardy Regional Council which on November 29, 2022, approved Law 25/22: for the first time in Italy, it recognized the right to independent living and social inclusion of all people with disabilities. "Regional Social Welfare Policies for the Recognition of the Right to Independent Living and Social Inclusion of All Persons with Disabilities" is the title of this regulation, whose ambitious goal is to put all persons with disabilities in a position to receive personalized support for the realization of their Life Project.

[2] Currently, in Italy, the following are part of the Third Sector Entities:

- Voluntary organizations
- The associations of social promotion
- The philanthropic entities
- Social enterprises
- Social cooperatives
- Association networks
- Mutual aid societies
- Associations, whether recognized or unrecognized
- Foundations and other private entities other than companies established for the pursuit, on a nonprofit basis, of civic, solidaristic, and socially useful purposes social benefit by carrying out, exclusively or principally, one or more activities of general interest in the form of voluntary action or free disbursement of money, goods or services, or of mutuality or production or exchange of goods or services, and registered in the single national register of the Third Sector (RUNTS).

Service professionals come to be highly specialized, despite the fact that the academic apparatus often fails to adapt to the rapidity of their specialization.[3] Social work is a big niche that has internal sources of research and literature, not necessarily academic, with a declared professional vision that is recognized internally but is almost invisible, externally. As Franca Olivetti Manoukian (1998, p.81) writes

> Professional qualification more than a formal attribute is a sign of belonging, an important element of work identity, to which are linked models of thought, action and relationships proposed to the individual in the stages of socialization to the profession and reinforced by the individual himself in daily interactions and actions. Each profession has its own tools and privileged objects that are translated into specific products/services, products as such visible and appreciable, exposed to social evaluation and bringing esteem or discredit: they contribute to constitute the image of self at work.

If the external image is faltering and the internal image is fragmenting, one wonders what drives these professionals to work as hard as they do, especially considering the constraints posed by new (weak) forms of labor contracts of the third sector that generate low salaries or precarious career paths and the anxieties and dramas that are inscribed in the consciences of most workers. Social work seems to have remained one of the last vocational professions that respond to an internal calling that is difficult to understate. Unfortunately, as in many other professional cases, this implies that those who manage this workforce, who are generally aware of the need for this job calling, may exploit all its inherent power. There is more energy in the social, medical, and paramedical profession than in most other areas of work, including education. People work in teams without doing team-building courses, manage budgets, human and financial resources, clients (patients and care recipients), do marketing actions to get funding for special projects, and seek connections with the art world to communicate special messages, all in addition to their specific role—all activities that are recognized and valued within companies and that are taken for granted in this area. The question remains as to how long we will be able to count on these natural talents: as mentioned earlier, the gradual dismantling of welfare systems does not seem to be moving in the direction of supporting adequate organizational structures. The more parceled and outsourced work becomes, the more these resources will be depleted.

Equity is certainly the idea underlying most legislation efforts, both at the central and regional levels. The major front in Italy on this dimension is women's equity (e.g., generally framed as "equal opportunities" in public discourse), and only secondarily migrants' access to healthcare—the first being on the agenda of every government, the second being on the attention of scholars and advocacy groups. Gender parity has had a big boost of attention over the last 20 years, thanks to diversity efforts and thanks to the EU prodding systems for putting the issue in the public debate. As an example, a large number of for-profit companies with more than 50 employees are adhering to the ISO30415 international standard published in 2021. This provides a guideline for companies wanting to adopt an inclusive approach that values diversity in the workplace. We cannot say the same for not-for-profit organizations and the system of social services and healthcare that are highly composed of female individuals. Gender gap in salaries, double presence, and child and elderly care are only some of the issues at stake. While a lot has been done, there still is a need to tackle important issues of representation, power, and care.

If it is the case that managing diversity is a necessity for Services in the coming decades, it is unclear that regulatory approaches will make substantive changes. The problem of diversity representation within the Services is not just a question of rights; when rights remain on paper, there is no real social innovation, only its potential. Instead, the identity groups that coexist within organizations, more or less formally, can make these rights substantive through relevance. Within the mission of Social Services in a multi-

[3]There are very few professors in Italy with an "ad hoc" academic placement for the Social Services and paramedical professions, so there is a lack of departments and PhDs that would allow for faculty turnover and the renewal of literature and studies in the field.

cultural society, for example, there is the intent to promote access to Services for all with a view to solidarity and social justice. How do we promote access to Services for segments of the population that have never availed themselves of services for self-exclusion or perceived denial? For instance, the Chinese population residing in Italy for generations has for many reasons remained isolated from other groups but also from contact with the Services. If we think of the latter as contexts of prevention and not only of providing forms of support, it is also understandable how useful it could be to involve the largest possible number of people living in our society. Practitioners can be trained in academia and through lifelong education, but the most immediate way to make the organization, however fragmented and precarious, ready for its mission is to know how to better use internal resources. Are there identity groups? They can be used to better understand the clients, their problems, and in the best of cases help them realize their autonomy, even if it is thought of differently from a cultural viewpoint. In this sense, most recent approaches to diversity speak of Diversity, (Equity), Inclusion, and Belonging. Within the organization, people must be able to accept and understand the perspective brought by identity groups in order to make it an added value. In healthcare, *equity* is defined as "the principle underlying a commitment to reduce – and, ultimately, eliminate – disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions" (Braveman, 2014). The case for equity is even more stringent in the case of hospitals and healthcare institutions as they are large and complex systems. As a small illustration: once a group of people who have been exposed to these issues via specific training has been established, a higher level of sensitivity to cultural difference is created. It is time to introduce innovation: why not create task forces, i.e., groups trained on the basis of a task, e.g., on the basis of ethnicity or national or regional culture to represent that perspective to colleagues? This type of intervention increases the overall learning of the organization with respect to certain issues, but also the leadership of its members. When knowledge is possessed internally, it is more "real," almost more natural. Thematic task forces are a reality in the global operations of many companies, which moreover are even formed virtually, among people who hardly ever see each other in person. Once relevance is established and goals are clarified, they can work very effectively and instill great enthusiasm in the organization. They provide support for the change agency undertaken by managers and help to make a shared vision, the cornerstone of successful change. Once the phase of an innovation is over, it is necessary to stabilize or institutionalize the new ways of thinking through new ways of working, observing, describing, and managing the day-to-day operations. Are entry questionnaires not working? It is time to think of other forms to obtain information at entry. Is there a campaign in place to prevent alcohol abuse among young people? How to reach out to culturally diverse groups in the area? How to take the different perspectives? What options to activate while respecting the sensitivities of each one? It is in this view that diversity can become innovation and creativity, and the idea that it only brings fragmentation can be opposed: the habit of recognizing internal diversity makes external diversity more natural, even more interesting.

4 The Empirical Case: Organ Donation and Transplantation in Relation to the Needs of Migrant and Ethnic Minority Populations in Italy

Since the beginning of the 1990s, both in the United States and Europe, sociologists and scholars have been talking about systemic inequities in the treatment of patients and clients with different ethnic backgrounds (Herholz et al., 1996; Aynian et al. 1993, 1999; Hannan et al., 1999; Johnson et al., 1993; Epstein et al., 2000, Petersen

et al., 2002; Terraneo & Tognetti Bordogna, 2018; Consolazio et al., 2020). In Italy, there is a general perception that, since access to healthcare and social services is universal, inequities do not exist. There is empirical evidence, though, of differences in how people are treated depending on their skin color, economical and juridical status, or different belief systems. North American literature (e.g., Bobo, 2001) enumerates cases of bias, discrimination, and stereotyping at the institutional and individual level, issues that go beyond the known problems of disparities caused by the insurance coverage system. It also considers the fact that in some cases, racial and ethnic minority patients do refuse treatment; nevertheless, refusal rates are generally small and may not fully justify the phenomenon. Other partial explanations are given by the (1) patients' lack of proficiency of the local language; (2) temporal and economic constraints on healthcare professionals leading to reduced timing for assessments and treatment; (3) hard-to-reach geographical locations of care facilities; and (4) poor communication of the array of available services (mostly for—but not limited to—social services) (Castiglioni, 2013).

The scientific case we have selected touches many of the areas illustrated so far. It is an example of the intertwining levels of DEI in the hospital setting, and the interrelationship with the broader societal context. It also presents the other side of inclusion, namely the reciprocity needed to operate and thrive in a multicultural society.

In accordance with the general European trend—particularly around healthcare services—of studying and advocating for more equitable accessibility and quality of care, scholars, institutions, and scientific societies have emphasized the ethical duty to reduce inequities in the process of organ donation and transplantation (ODT) among the most vulnerable and/or socially deprived communities, including immigrant groups (Grossi, Paredes, Palaniswami, et al., 2023; Vanholder et al., 2021; European Kidney Health Alliance, 2019; European Society of Organ Transplantation, 2022). A review of inequities among these communities at the different stages of the ODT process found that, in the European context, most studies are retrospective,[4] focused on kidney transplantation, and, most importantly, that consensus is lacking the categorization of these populations (Grossi, Randhawa, Jansen, & Paredes, 2023). While the European Public Health Association acknowledges the controversial definition and categorization of "ethnic minorities" in Europe, it stresses that, regardless of how these populations are defined and categorized, the features related to "ethnicity" are frequently rather independent of "immigrant status" (European Public Health Association, 2018). Besides, (1) individuals who have migrated from other countries or who are from ethnic minorities in Europe are likely to experience similar health inequities (Bhopal, 2014; European Public Health Association, 2018), (2) biological features vary among ethnic groups (Gordon, Ladner, et al., 2010), and (3) individuals belonging to visible ethnic minorities may experience more significant inequities (Llácer et al., 2007). Based on these considerations, Grossi et al. have argued that both the features related to "ethnicity" (including country of origin or descent) and "immigrant status" (or immigration history) should be considered for the purposes of studies in relation to ODT. Yet, research is currently lacking on the intersection with the multiple factors associated with each of them[5] (Grossi, Randhawa, Jansen, & Paredes, 2023).

Discrepancy between the number of patients waiting for transplant and that of *post-mortem* organ donors is seen in many countries, although there are differences (EDQM Council of Europe, 2022). When taking a closer look at waiting lists, ethnic minorities appear to be disproportionately represented, whereas the number of *post-mortem*

[4]Retrospective studies are not always adjusted for all potential confounders; therefore, they are unable to determine the actual impact of the factors associated with ethnicity and immigrant status on inequities across the ODT process.

[5]It is well-established that ethnicity and immigration background do not operate in isolation but intersect with a variety of socioeconomic factors at the individual level, and with other factors at the interpersonal and societal level (Grossi, Paredes, Palaniswami, et al., 2023; Grossi, Randhawa, Jansen, & Paredes, 2023; Grossi, Puoti, Masiero, et al., 2023).

organ donors from these communities is generally low, and, in the organ donor register (for example in the UK), more people identifying as White are present on the donor register relative to other ethnic groups (Pedder Jones et al., 2019). For instance, data from Europe (including the UK) and North America show that some migrant and ethnic minority groups have a higher risk of developing end-stage organ disease (especially kidney disease), are disproportionately represented in the patient population requiring renal replacement therapy, and wait longer to receive a kidney transplant when compared with the White population (Ladin et al., 2009; Randhawa & Gardiner, 2022). The number of *post-mortem* organ donors being lower among migrant and ethnic minority communities is due to several reasons, which may not certainly be attributed to a lack of reciprocity, but rather to the intersection among many factors (Grossi, Paredes, Palaniswami, et al., 2023; Grossi, Puoti, Maggiore, & Cardillo, 2023; Grossi, Puoti, Masiero, et al., 2023), as explained in further detail later in the chapter.

Immigrants are a heterogeneous group; reasons for and circumstances of migration have a great variation. Migration pathways depend on migration history, immigration policies, social security systems, and other societal features at the level of single countries (Douglas et al., 2019). However, these populations are often exposed to structural inequities which may increase health risks at each stage of the migration process (e.g., before migration occurs, during the migration process, during integration, and after return to countries of origin). Risks may increase because of cultural, linguistic, and relational difficulties, disadvantaged socioeconomic conditions, discrimination, lack of knowledge of healthcare systems and administrative regulations in host countries, and the lack of culturally competent healthcare services. The interplay among these factors may lead to inequities in healthcare accessibility and quality, even in countries with universal healthcare coverage like Italy (Ballotari et al., 2015; Di Napoli et al., 2022). Given the recent surge in immigration, adult immigrant and ethnic minority groups in Italy tend to overlap (Italian National Institutes of Statistics, 2020). Italy ranks third in Europe in the total number of regular residents with non-EU citizenship (5.2 million) (Eurostat, 2022). Of these, the most numerous are the Romanian, Albanian, Moroccan, and Chinese communities (Italian National Institutes of Statistics, 2020). In Italy, immigrant populations are generally identified as vulnerable groups.[6] For instance, non-European-born individuals in Italy are more likely to be socioeconomically disadvantaged, with difficulties in oral and written communication, and, when compared with individuals who have migrated to other EU countries, with a lower educational level (Di Napoli et al., 2022; ISMU, 2019). While most immigrants are younger and healthier relative to native-born referents, similarly to European data, a large segment of first-generation immigrants in high migratory pressure areas in Italy has end-stage kidney disease (ESKD) (7.6–35%) (Corghi et al., 2016; Di Napoli et al., 2015; Forneris et al., 2011) and liver disease (9.2%) (Affronti et al., 2014). These populations present also significantly higher rates of diabetes, obesity (especially among subjects of Southeast Asian and Northern African origin), and other risk factors (e.g., hypertension) for the progression toward organ failure (especially ESKD) requiring replacement therapies (Ballotari et al., 2015; Buja et al., 2013; Gibertoni et al., 2022).

Italy has a universal healthcare system which guarantees organ transplantation regardless of ethnicity, immigration background, religious beliefs, gender, socio-economic status, health literacy, linguistic difficulties, or cultural diversity.

[6]It must be noted that, as highlighted by the Office of the United Nations High Commissioner for Human Rights, "Migrants are not inherently vulnerable, nor do they lack resilience and agency. Rather, vulnerability to human rights violations is the result of multiple and intersecting forms of discrimination, inequality and structural and societal dynamics that lead to diminished and unequal levels of power and enjoyment of rights. As a matter of principle, and in order to ensure that every migrant is able to access appropriate protection of their rights, the situation of each person must be assessed individually" (Office of the United Nations High Commissioner for Human Rights, 2018).

However, evidence from other healthcare settings has shown inequities in accessibility, quality, and outcomes of care among immigrant populations (Ballotari et al., 2015; Di Napoli et al., 2022). Equity is a major principle in organ transplantation; tackling inequities is critical to ensure that all people achieve the best possible health outcomes and addressing them is key for the trustworthiness and transparency of transplant systems (National Academies of Sciences, 2022).

ODT is a complex process with many clinical, psychosocial, and cultural factors that may be associated with immigrant status. Patient and family education and informed consent are keys for the provision of equitable care throughout the entire ODT process. Shared decision-making is the most desirable and ethical model of informed consent at all stages of the ODT process but may be impeded by multiple factors at the level of patients, providers, the clinical encounter, the healthcare system, and the broader societal context (Suurmond & Seeleman, 2006). For instance, despite a publicly funded health system with universal healthcare coverage, non-European-born individuals living in Italy are less likely to receive kidney transplants from related living donors and more likely to have less favorable long-term kidney graft function compared with EU-born and Eastern European-born patients (Grossi et al. 2020; Grossi et al., 2022). Further, while immigrant patients are increasingly represented among transplant recipients (especially kidney and liver transplants), refusal rates for organ donation are higher in some ethnic groups compared with native-born and other foreign-born referents (Grossi, Puoti, Maggiore, & Cardillo, 2023; Grossi, Puoti, Masiero, et al., 2023).[7] Besides, immigration may also contribute to different exposures to opportunistic infections during travels to home countries, and ethnicity may be associated with higher alloreactive immune reactions or metabolism of the required lifelong immunosuppressive medications. The impacts of social determinants of health associated with immigration may also account for a portion of unfavorable trends in kidney transplant outcomes (Grossi et al., 2020).

Qualitative studies of the perspectives of relevant stakeholders, the lay public, bereaved family members, patients pursuing transplant, (potential) living donors from immigrant communities, and transplant centers and intensive care units' healthcare professionals will be performed in the near future. Such studies will inform on the potential barriers to transplant care at the individual, interpersonal, and the societal level to identify potential areas for intervention (Grossi, Puoti, Masiero, et al., 2023). In addition, evidence is lacking on the patient's experience throughout the various stages of the ODT pathway (from end-stage organ disease onset through to post-transplant follow-up). These studies could provide insights into the factors which may have negative downstream effects on the outcomes of transplantation for individuals with an immigration background. Survey studies are also currently ongoing among migrant and native-born communities, and among healthcare professionals to identify additional areas for intervention in terms of healthcare professionals' diversity competence and organizational diversity responsiveness (Grossi, Puoti, Masiero, et al., 2023).

The higher refusal rates and reduced live donation among ethnic minority populations have the potential to increase the waiting time for transplantation (Morgan et al., 2015; Randhawa & Gardiner, 2022), and the inability to match

[7]Studies of inequities in ODT among immigrant populations residing in Italy include individuals with extreme diversity of cultural, religious, social and immigration backgrounds. These are major limitations as these aspects may significantly bias the interpretation of the results and the potential for intervention. Besides, because there can be great within-group variation, studies are needed to collect data to enable better understanding of the many factors intersecting with immigration (e.g., socioeconomic status, educational and occupational background, country of origin or descent, reasons for and circumstances of migration, time elapsed since immigration as a proxy for acculturation and integration, language proficiency, local integration policies, and other systemic features which may vary among regions). Another limitation lies in the small number, size, and limited quality of studies, and exclusive focus on end-stage kidney disease and kidney transplantation. None investigated possible differences in the need for organ transplantation among resident versus more vulnerable immigrant categories (e.g., refugees, asylum seekers, undocumented immigrants).

donor and recipient ethnicity may negatively impact on patient and graft survival (Allen et al., 2009; Kanter et al., 2009).

As noted earlier, discrepancy between transplantation and refusal rates for organ donation (Bhopal et al., 2019; Grossi, Puoti, Maggiore, & Cardillo, 2023; Grossi, Puoti, Masiero, et al., 2023; Randhawa & Gardiner, 2022) is not indicative of a lack of reciprocity or unequal contribution to organ donation among immigrant populations. Rather, as for the other phases of the ODT process, they are likely a reflection of multiple, intersecting factors. Among immigrant populations, the lack of knowledge regarding ODT, varied cultural and religious beliefs, low health literacy, lack of trust towards the healthcare system and healthcare professionals in the host country, a systemic inability to communicate about ODT in a culturally sensitive fashion, and the background framework of ODT in the country of origin with fear of organ trafficking, unfairness, lack of transparency, or general mistrust towards the healthcare system may contribute to negative attitudes towards organ donation in some immigrant groups (Grossi, Puoti, Maggiore, & Cardillo, 2023; Grossi, Puoti, Masiero, et al., 2023; Kentish-Barnes et al., 2019; Morgan et al., 2016; Randhawa & Gardiner, 2022; Randhawa & Neuberger, 2016).

Current approaches to communication, patient education, and management are less likely to be effective with subjects from immigrant and/or ethnic minority groups. Targeted/tailored interventions to meet the needs of these populations remain limited in Europe. Studies have advocated for a coordinated approach to empower these individuals at all stages of the ODT process by encouraging participation and inclusion (Grossi, Paredes, Palaniswami, et al., 2023). Studies in the UK (Randhawa & Neuberger, 2016), Spain (Generalitat de Catalunya, 2022), and the Netherlands (Ismail et al., 2014) have attempted to improve dialogue with diverse ethnic and faith communities to empower healthcare professionals to deliver more culturally competent and family-centered approaches regarding organ donation and living donor kidney transplantation (Generalitat de Catalunya, 2022; Morgan et al., 2016). Experiences from beyond Europe have shown that culturally and linguistically competent websites or transplant-center-based education to empower specific ethnic minority groups by targeting their needs may equally prove useful (Gordon et al., 2016; Gordon, Caicedo, et al., 2010).

In Italy, multilingual donation-related informative material and courses on ODT for cultural mediators and other healthcare professionals involved in organ procurement in some centers have improved the cultural appropriateness of end-of-life care (Potenza et al., 2013, 2015). Further, some transplant centers have developed multilingual educational material for immigrant patients pursuing transplants. However, these interventions remain sparse, requiring a systemic, more harmonized, and coordinated approach. The Italian National Transplant Center (CNT) has initiated a project titled "Fostering And Improving equity, participation and inclusion in Transplantation Healthcare" (FAITH) (Grossi, Puoti, Masiero, et al., 2023) consistent with the European Society of Organ Transplantation policies (European Society of Organ Transplantation, 2022) to adapt ODT communicative, educational, and management processes to the needs of immigrant communities, families, and individuals.[8]

It is well established that there can be no "one-size-fits-all approach" to immigrant populations. For instance, because there can be great within-group variation, studies should collect data to enable better understanding of the many factors intersecting with immigration. Potentially confounding factors include, but are not limited to, socioeconomic status, educational and occupational background, country of origin or descent, reasons for and circumstances of migration, time elapsed since immigration as a proxy for accul-

[8]The project contends that, to enable the prevention of inequities, interventions should be implemented to target not only communities and/or individuals with an immigration background but also those who relate with them, namely institutional actors, intensive care units' and transplant centers' healthcare professionals, and the contexts where these processes respectively occur (e.g., the societal context [especially relative to the healthcare system—with a focus on healthcare organizations—and policies]) (Grossi, Puoti, Masiero, et al., 2023).

turation and integration, language proficiency, local integration policies, and other systemic features which may vary among regions. Therefore, Italian findings might not apply to immigrant populations residing in countries with a different healthcare and social security system, with longer-standing immigration history, or to second- or third-generation immigrants (e.g., subjects who were native-born of foreign-born families).

By the mid-2050s, ethnic minorities will make up nearly half of the Western European population. This illustrates the need for all countries with increasingly diverse ethnic populations to invest in the development of a whole-system approach to commissioning preventative and transplant services to satisfy the future requirements of an increasingly multiethnic older population (Wilkinson et al., 2016).

Providing end-of-life care to patients from different cultures is a challenge for services as there can be barriers to communication in the form of language, delegated decision-making within families, and reluctance to discuss about death (Deedat et al., 2013; Kentish-Barnes et al., 2019; Morgan et al., 2016). It is important that solutions to DEI in end-of-life care are taken synchronously with developing culturally competent approaches to organ donation (Kentish-Barnes et al., 2019; Morgan et al., 2016).

Demand for transplantation can largely be reduced if there is a sustained commitment to public health interventions and culturally competent approaches implemented in the management of long-term conditions, recognizing the heterogeneity of diverse migrant and ethnic minority populations. Improved access to transplantation and reduced waiting times can be achieved if there are concerted and adequately resourced efforts to increase the number of organ donors from minority ethnic groups. This vision of equity and inclusion can only be realized by adopting a culturally competent approach to systems-wide working in organ donation in four core areas: public engagement, disease management, staff training, and transplant services (Randhawa & Gardiner, 2022).

Because inequities are documented among migrant and ethnic minority populations in the entire ODT process, a "care pathway/whole-systems" approach to ODT encompassing culturally competent public health interventions is needed for improved (a) prevention and management of chronic conditions, (b) public engagement for the promotion of the culture of ODT and enhanced end-of-life care, through to (c) enhanced likelihood of successful transplant outcomes among migrant/ethnic minority communities (Grossi, Randhawa, Jansen, & Paredes, 2023).

It is possible that gaps may persist because of inequalities at the broader societal level and biological variations in some ethnic groups. However, it is a compelling ethical duty to consider inequities engrained in modifiable factors.

5 Conclusion

While this case is a rather specific one, it certainly demonstrates the complexity of the issue of the recognition of diversity, of an equitable access and treatment of patients/users to services. Competence for making our societies more inclusive needs to be seen as a circular process, much like the circular economy has become memetic for newer generations. For instance, not only is diversity an internal challenge to organization, it also is crucial for the provision of services. Additionally, the case shows that providing equitable access and care is not enough in the multicultural society if ethnic minorities are not as sensitized, in culturally appropriate ways, to reciprocation, in this case, to the donation of organs. The case of reciprocity is becoming compelling in societies that want a thriving coexistence of diversities. By failing to stress the recognition of diversity, we are giving up the potential for creating conditions of reciprocal respect, without which inclusion and equity can become empty slogans.

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