Debates and Controversies

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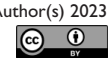
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Assisted Reproductive Technologies and Work, Employment and Society: Extending the Debate on Organisational Involvement in/Responsibilities around Fertility and Reproduction

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Abstract

A relatively recent development in the field of work and employment is organisational provisions around employee fertility – notably policies and benefits related to assisted reproductive technologies, also known as fertility treatment. Work, employment and organisation scholars have only scratched the surface of this issue. This Debates and Controversies article takes an intersectional political economy approach to explore the opportunities, challenges and dilemmas at the interface between assisted reproductive technologies, society, employment and work. We consider how 'stratified reproduction' may be affected by employer interest in assisted reproductive technologies; what employers may gain, risk or lose by developing provisions; how assisted reproductive technologies-related 'reproductive work' intersects with paid employment; and the possible consequences, including occupational stratification due to assisted reproductive technologies-related career penalty. We call for further research, especially focusing on the

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most disadvantaged in society and employment, and approaches to workplace support led by compassion over cost-benefit calculation.

Keywords
Assisted Reproductive Technologies (ART), employment, fertility treatment, gender, inequality

Introduction

Work and employment scholars have neglected pre-conception and the non-reproductive body, focusing reproduction attention on pregnant and maternal bodies (Cervi and Brewis, 2022). According to the World Health Organization (2020) however, infertility is a disease of the reproductive system affecting 15% of reproductive-age couples. While often caused by specific medical condition(s), cause(s) can be unexplained, or due to sexual orientation, or lack of a partner ('social infertility'). Infertility is a socially constructed as well as biological phenomenon (Barnes and Fledderjohann, 2020) and lived experience is connected to an individual's socio-cultural positioning, which for most involves engagement with paid work. Advances in Assisted Reproductive Technologies (ART), otherwise known as fertility treatments, have created new opportunities to tackle infertility but also new controversies, and access is not equal. With organisations – predominantly employers of professional staff in the Global North – showing increased interest in ART in relation to employee benefit and/or wellbeing provisions, this brings new questions for organisation studies scholars, including around the public/private divide and equality.

This Debates and Controversies article draws on intersectional political economy (Atkinson et al., 2021) as a guiding framework to consider the interface between ART and employment, focusing specifically on how 'stratified reproduction' (Ginsburg and Rapp, 1995) may be affected by employer interest in ART; what employers may gain, risk or lose by developing provisions; and how ART-related 'reproductive work' intersects with paid employment for individual workers, and the consequences – which we argue may include furthering gendered occupational stratification.

As developed by Atkinson et al. (2021), an intersectional political economy approach integrates feminist political economy, which 'insists on gendering a macro-level political economy analysis of relationships between individuals, the state, the economy and wider society' (Atkinson et al., 2021: 50) and intersectionality theory (Crenshaw, 1989), which allows for consideration of multiple intersections of 'meso- and micro-level self-identifications and identifications performed by others' (Atkinson, et al, 2021: 50) beyond (in)fertility status, including occupation, class, employment type, income, gender, sexual orientation, race, ethnicity, age, (dis)ability, and migration status in workplace analysis. An intersectional political economy approach allows us to think of infertility and fertility treatment experiences as more than physiological or even psychological, but something shaped by specific socio-cultural location. It calls for consideration of how macro-, meso- and micro-level factors have led to (limited) employer interest in ART and the ability of individually positioned employees to navigate ART alongside work.

This article is structured in three main sections. 'ART and society' sets the scene for employer interest and employee experience by focusing on the macro-level. We show how social attitudes towards infertility and ART alongside international variation in regulation and access add to 'reproductive stratification': the circumstances whereby 'some categories of people are empowered to nurture and reproduce, while others are disempowered' (Ginsburg and Rapp, 1995: 3). 'ART and employment' addresses the meso-level, especially the extent to which employer fertility provisions mitigate or intensify reproductive stratification, highlighting, specifically, the lack of provision for the most vulnerable workers globally. We also discuss employer motives, risks and rewards in developing fertility benefits, policies and other offerings. 'ART and work(ers)' addresses the micro-level – the challenges for individual workers linked to their intersectional positioning, and draws out possible consequences for individuals and broader meso-level dynamics, specifically in relation to broadening gendered occupational segregation.

Macro-level influences: ART and society

Feminist political economy approaches suggest that experiences, including health experiences (see Syed, 2021), cannot be understood without reference to the macro-level context within which they reside, including culture and structural factors like laws and government policy (Atkinson et al., 2021). In this section we consider how the experience of infertility and the potential of new technologies aimed at addressing infertility are shaped by international variation in social attitudes, legislation and funding, leading to reproductive stratification. This sets the scene for considering the intersection with work and employment.

Infertility is both an individual and a social problem shaped globally by different cultural norms around family-making and who 'should' and 'should not' be encouraged to reproduce (Saunders, 2021). Using biopsychosocial theory, Gerrity (2001) describes infertility as both a life crisis and a non-event that affects individuals, couples and families in various stressful ways (body, mind and emotions, sense of self and relationships). Infertility has been linked to depression, anger, guilt and suicidal thoughts (Greil et al., 2010) as well as deviance from the norm and 'felt stigma' (Todorova and Kotzeva, 2006). The latter is linked in part to pronatalism in many countries (Blyth and Moore, 2001) with falling birth rates being problematic for a sustainable workforce (World Economic Forum, 2022). While most infertility focus is on women, contemporary research repudiates earlier claims that men are less distressed (Fisher and Hammarberg, 2017), with evidence of negative impact on identity and masculinity across the life-course (Hadley, 2021).

ARTs have been termed 'hope technology' (Franklin, 1997) for the ability to tackle and reframe infertility from a 'problem of manhood/womanhood' to a 'problem of health' – a disease like any other – helping the issue 'come out' from behind a 'veil of secrecy' (Inhorn, 2020: 49). Since the world's first human baby was born by in vitro fertilisation (IVF) – the most well-known ART procedure – in 1978 in the UK, over nine million IVF babies have been born globally (European Society of Human Reproduction and Embryology (ESHRE), 2020) and ARTs have burgeoned and become ever more sophisticated (see Carroll, 2019), including egg-freezing and intracytoplasmic sperm injection

(ICSI). ART is largely positively accepted and increasingly normalised in Europe, the US and Middle East for heterosexual (in particular, married) couples (Inhorn, 2020). As well as addressing medical infertility, ARTs offer a route to biological parenthood in 'non-standard situations and relationships' (ESHRE, 2014: 1859), including single women without a male sexual partner, and same-sex couples who might otherwise pursue riskier informal routes to pregnancy (see Cashmore, 2018) and parenthood. While fertility treatment usually plays out more significantly on the female body (medication injections, tests, procedures and scans), Inhorn (2020) suggests the eager uptake of ICSI has made the 'quest for conception' increasingly masculine, with potential to influence gender norms more broadly. She also notes how egg-freezing creates new possibilities for transgender men.

There are however significant caveats to the 'hope' brought by ART. The successful metric for IVF is live birth, and the overall birth rate for IVF in the UK is just 23% (Human Fertilisation and Embryology Authority [HFEA], 2021), dropping below 5% for women aged 43+ using their own eggs. Loss can be experienced at different stages, and mental health challenges are common, which may continue beyond conception (see Hjelmstedt et al., 2003). There is also huge international variation in infrastructure, regulation and access (Fauser, 2019), linked to particular 'repronational histories' (Franklin and Inhorn, 2016: 4). Global South countries, such as those in Africa, have high infertility levels, and yet policy attention and fertility care remain limited (Fauser, 2019). In the Global North, the absence of transnational legally mandated bioethical guidelines (Smietana et al., 2018) means significant variation in overall regulation and attitude to specific issues, such as parental rights in donor conception. This is accompanied by national variation in healthcare systems and access to publicly funded treatment, which is rarely universal. Whilst Israel leads the way in terms of funded treatment (covering all procedures until the birth of a first and second child under the National Health Insurance Law; see Medina-Artom and Adashi, 2020) the US provides no public healthcare provision and little insurance coverage. In the UK, while there are some National Health Service (NHS) provisions, these are geographically variable, and tied to likely success criteria (including woman's age) and other factors. In part, this relates to historical debate about the 'necessity' of ART versus other healthcare needs (Lord et al., 2011).

Internationally, the cost of private treatment is a key barrier to uptake, with clear class and income intersections. Barriers also exist for those stigmatised concerning family formation in 'non-standard situations and relationships' (ESHRE, 2014: 1859; Smietana et al., 2018) with IVF initially framed around heterosexual married couples (UK Department of Health & Social Security Report of the Committee of Inquiry into Human Fertilisation and Embryology (Warnock report), 1984: 10–11). Ethnic minority groups and people living with disabilities have also faced discriminatory issues around access and quality of care (see Inhorn, 2020). ART cost, regulation and access inequalities have led to increasing cross-border 'repro-travelling' (Inhorn, 2015), but this is not an option for all – as it requires time, money and knowledge. Mental health support through treatment journeys is also limited.

There are, thus, emergent reproductive stratifications in relation to the nexus between infertility and ART across dimensions of nationality, access to social and cultural capital (or class), ethnicity, disability, gender, sexual orientation, relationship status and age. We

know that such personal characteristics, and their intersectionality, have a bearing on jobs, occupations and careers, so it seems likely that certain types of worker globally will be more constrained in family building, including those in the Global South; those forced to migrate for work; those in lower paid, precarious work; and those from minority groups. Employment legislation and organisational investment in employee ART-related provisions, which we elaborate on in the next section, has the potential to mitigate gaps in healthcare provision and inequalities, but when this is extremely limited (as is the current case) it may instead broaden reproductive stratification.

Before turning to the meso-level of employment and employers, it is worth acknowledging at this point the role of the fertility industry and its ongoing commercialisation in informing meso-level developments and micro-level experiences. Several questions and controversies arise when employers develop an interest in ART, potentially positioning fertility clinics (and associated businesses mediating the relationship between employers and clinics) as suppliers of services to corporations rather than patients. Might increased business-to-business transaction exacerbate commercial drive and potentially influence practice and decision-making in ethically questionable ways? Might there be more psychological detachment in fertility professionals, and less qualms about pushing expensive add-ons or downplaying limited success rates when corporations become the customer? There is already debate in the UK around the ethics of add-ons – tests, drugs and practices, often at additional cost – that clinics claim will improve live birth rates but for which supporting evidence is limited (Stein and Harper, 2021). Would narratives be less around 'care' (Cervi and Brewis, 2022) for vulnerable patients, and more about 'minimising business disruption', and how would this affect the lived experience of those struggling with complex fertility?

The meso-level: ART and employment

Bringing intersectionality in alongside feminist political economy allows for consideration of the meso-level factors influencing experiences of infertility and ART access, specifically in relation to class, occupation, employment type and income. In this section we focus on the current state of employer interest in ART, and notably the type of employers showing interest, and what this means for reproductive stratification. We also discuss the risks and rewards for the employers venturing into this area.

There are inherent complexities around employer interest in ART, linked to the macro-level context, the organisation strategy and the type of workers. The driving forces for organisational support around ART are changing social attitudes, awareness and expectations; the 'war for talent' in many sectors; and rising 'wellbeing at work' and Equality, Diversity and Inclusion (EDI) agendas. Yet these forces confront the reality that many organisations remain hostile places for family-building, with the 'ideal worker' (Acker, 1990) remaining one largely unencumbered by responsibilities outside work. Employment legislation to protect and support pregnant women/new parents (making discrimination unlawful and ensuring safety, leave and pay) varies hugely internationally and is not always adhered to. At present, few countries have bespoke employment legislation around ART. The exceptions are Malta, Korea, and Japan, who offer paid leave and/or protection from discrimination for at least some workers[1] (Koslowski et al., 2021). The UK Government is currently considering proposals (UK Parliament, 2022).

The combination of driving forces and constraints – including absence of legislative pressure in most countries – means that employer ART-related supports usually rest on business case cost-benefit calculation, likely to exacerbate reproductive stratification. Investments around ART originated in US technology firms in Silicon Valley (Apple and Facebook in 2014), who acknowledged the costs of ART combined with lack of insurance coverage and saw fertility benefits (private egg-freezing and IVF) as an employer branding opportunity. This appears savvy if we consult recent surveys of (especially younger) worker attitudes (see Willis Towers Watson 2019),[2] but only certain workers benefit. Reporting on the 2021 Fertility IQ US Family Builder Index, a Monster Jobs article notes the best coverage being for those working in technology, consulting and accounting, banking and finance, fashion, and media (Martis, n.d.).[3]

In the UK, where public health ART provisions are more generous, attention has been paid to fertility treatment policies (time off/flexibility) and associated provisions over financial subsidy. While the narrative is wellbeing, the business case is similarly foregrounded, with specialist advice/advocacy organisations highlighting the impact of supportive policies on employee retention, absence, performance and engagement. This influences who listens. It is telling that the UK's first specialist 'Fertility Officer' is in a law firm (Beal, 2022). More broadly, provisions remain rare. In the 2022 Chartered Institute of Personnel and Development (CIPD) Health and Wellbeing survey, just 3% of responding organisations offered significant provision for fertility challenges, making the topic (alongside menstruation) the least catered for amongst wellbeing issues for specific employee groups (CIPD, 2022: 15). Whilst evidence is limited, the same can be seen elsewhere. A 2017 Japanese government survey (in Ikemoto et al., 2021) reported little ART-related provision, with just 6.2% of responding organisations offering leave, and 1.9% offering financial subsidy.

Given the above, certain types of employee are likely to be the most disadvantaged in family-building, because their employers cannot or will not offer fertility-related supports: employees in the private sector whose employers operate on a 'churn and burn' HR model, offering little in the way of employee benefits/support and tolerating high turnover (see Burgess et al., 2019); those in companies with fewer resources such as Small and Medium sized Enterprises (SMEs); and those with the least bargaining power. The issue is exacerbated for those in non-standard (casual, self-) employment, which is highly prevalent especially in the Global South, with women, minority groups and migrants most vulnerable (Jaga and Ollier-Malaterre, 2022; Van Doorn et al., 2022). Organisations benefiting from such workers are unlikely to offer broader facets of decent work that make the pursuit of ART feasible, such as job security, decent wages, sick pay, or protection from dismissal. There are also commercial winners and losers. Employers already struggling to offer competitive employment packages could lose talent or be forced to direct funds away from other important areas.

Where policies exist, early evidence suggests failure to cater for the full spectrum of employee needs (Wilkinson et al., 2022). Policies in the UK often focus on a set number of days off (per year or treatment cycle) for clinic appointments, setting a normative template when at least some employees need support and flexibility for longer. They mirror broader organisational work-family provisions in inadequately supporting partners (Cook et al., 2021; Gatrell and Cooper, 2008) and non-traditional family identities (Anand and Mitra, 2021; Stavrou and Ierodiakonou, 2018). This further limits the

potential to redress societal reproductive stratification. There is little support for the broader fertility lifecycle, in terms of fertility education; fertility planning; pregnancy following infertility/ART and potential perinatal mental health issues (see Wilkinson, 2022); or unsuccessful ART, the grief of involuntary childlessness, and the emotion work of navigating this in the workplace (Mård, 2020; Mumford et al., 2022). This begs the question of what the emergent role of the employer is in family-building and where the boundaries should be.

It remains to be seen whether more employers will develop policies, and whether policies will evolve to address the shortfalls and inequalities outlined, but problems will remain when the issue is approached from a business case or employer branding perspective. Some employers will view ART support as an incentivising path that makes employees more 'problematic' – needing support for possibly repeated gruelling ART cycles before becoming pregnant/a parent (itself problematic for the employer) or having to come to terms with failure. They might be wary of accusations of encouraging vulnerable employees to pursue a course they are unable (financially or otherwise) to continue, or for exacerbating future-planning around work-life investment (Rottenberg, 2017) – encouraging 'false hope' or 'cruel optimism' (Berlant, 2011) in employees to exploit labour for longer periods. This has been seen for some time around the egg-freezing benefit, which reportedly one in four UK workers would view as a 'selfish attempt to retain talent' (Moore, 2017). Reputational damage may also ensue if provisions, even well-intentioned, fail to adequately cater for LGBTQ+ staff or other disadvantaged groups.

There are also issues to navigate around organisational justice and limited funds for wellbeing provision. Where stakeholders consider ART a lifestyle choice (following Lord et al., 2011), workplace ART-related support would likely be viewed as a 'perk', that should link to merit. How is this reconciled alongside those taking a needs-based perspective – itself tricky when different definitions of need are considered – or an equality-based perspective? Might there be backlash around further 'family-friendly' provisions if there is not similar support (flexibility, etc.) for other non-work issues/priorities (see Wilkinson et al., 2017, 2018)? There are additional complexities for multinational organisations, charged with navigating multiple legislative frameworks, healthcare systems and social attitudes (to both ART and stigmatised identities, see Stenger and Roulet, 2018) alongside organisational justice. There are new potentials here though, around the use of international assignments to support employee 'repro-travel' needs (Inhorn, 2015).

This is an area likely to evolve significantly, with employer actions shaped by, and in turn shaping, social attitudes, labour market trends, legislation and healthcare provision. Further research is needed on the decision-making of key actors, and the impact of organisational ART-related investment on worker reproductive stratification, which is amplified further when we consider the micro-level.

Micro-level considerations: ART and work(ers)

The integration of intersectionality into Atkinson et al.'s (2021) framework allows for detailed analysis of how engagement with ART, and employer provisions around ART,

play out for particularly positioned employees at the micro-level. From limited existing literature we can see how (in)fertility status and gender at the micro-level intersect with meso-level factors, in terms of occupation and employment type, to influence experience. In this section, we discuss the gendered 'reproductive work' required in ART engagement; its incompatibility with the demands of paid employment; and how this might actually further gendered occupational stratification (or segregation) (i.e. Huppatz and Goodwin, 2013) in terms of the kind of paid work and careers that some women are able to pursue. We also note the paucity of existing research on the workplace experiences of those with other intersectional positioning.

Becoming pregnant via ART requires considerable unpaid reproductive work, primarily for women. Gatrell (2013) notes how pregnant women are subject to highly prescriptive health and lifestyle advice, creating 'maternal body work', which is often at odds with professional or occupational requirements. Women navigating ART are subject to similar advice concerning diet, lifestyle, stress and complementary therapies from multiple sources (see Cervi and Brewis, 2022). There is then medication to administer, scans and procedures, perhaps surgery to address underlying conditions, side effects to manage, and for many, a 'wounded body' (Boncori and Smith, 2019: 81) to manage following cycle failure or early pregnancy loss – both physically and psychologically. Alongside body work, there are logistical requirements, in terms of managing unpredictable and sometimes daily clinic appointments, and administrative requirements in terms of researching conditions, treatments, healthcare access and providers.

Recent scholarship on the lived experience of navigating IVF in the UK shows how this reproductive work conflicts with paid employment (Griffiths, 2021; Payne et al., 2019). Furthermore, especially heart-breaking ART experiences can happen in the workplace; and there can be additional emotion work in navigating certain workplace interactions (see Mård, 2020), which may be exacerbated in certain, often female-oriented, job contexts (such as teaching and healthcare).

Decision-making around whether to disclose engagement with ART in the workplace adds work and stress (Van den Akker and Payne, 2016). As disclosure is necessary to receive workplace support, individuals are obliged to reveal more of their personal selves at work (infertility, ART intentions and for some, sexual orientation or relationship status). Silence is often preferred, for a variety of reasons. For a start, ART is linked to several issues that are unwelcome in the workplace – pregnancy/maternity, fragility, illness and loss (Boncori and Smith, 2019; Gatrell, 2011; Rose and Oxlad, 2022). In addition, ART may be possible to conceal; there is uncertainty over the outcome; and there is often little indication of how ART disclosure will be received, due to lack of legislation, policies or organisational narrative (Wilkinson et al., 2022). Occupational or organisational factors that facilitate or shut-down disclosure, in terms of culture, policies, communication channels and relationships may influence reproductive stratification, in terms of sending messages that reproduction is supported or not in that context; and enabling or preventing appointment attendance.

For those hoping to carry a baby in pregnancy, the physically gruelling, psychologically all-consuming, and logistically unpredictable nature of ART engagement can have a significant impact on occupational engagement and/or performance at work for affected employees (Durmazoglu and Alus Tokat, 2021). This can lead to career-related decisions

such as exit, going part-time, or not going for promotions or career-enhancing projects during treatment (Mumford et al., 2022; Wilkinson et al., 2022). It can also lead to discrimination from employers, especially in the absence of legislative protection. This labour market movement and lack of upward mobility likely exacerbates existing gender-based occupational stratification. Early evidence from the UK, Japan, Turkey and the US (Durmazoglu and Alus Tokat, 2021; Ichikawa et al., 2020; Imai et al., 2021; Noonan, 2022; Wilkinson et al., 2022) suggests an ART-related career penalty for women similar to the 'motherhood penalty' (McIntosh et al., 2012), especially for those undergoing multiple cycles.

This seems to be compounded by the positioning of non-carrying partners. The combination of ART playing out on female bodies; access to treatment often being contingent on finances; and the partner's role being minimised in organisation policy likely reinforces traditional male breadwinner narratives – adding pressure on partners to attend work, work extra hours or secure promotion when their needs may be very different. Indeed, Hanna and Gough's (2020) exploration of men's experience of ART and work emphasises the financial tolls. Were organisational policy to recognise the ART-related 'reproductive work' of partners – in terms of adhering to health advice, navigating the emotional rollercoaster, and supporting the individual undergoing treatment – and facilitate this (for example via reasonable adjustments and/or time off) it might set couples on a path to more balanced investments in care versus production work, and minimise the gender discrepancy in terms of organisational impact.

The extent to which ART-related reproductive work links to occupational stratification deserves further research, extending to consideration of ethnicity, sexual orientation, relationship status, age and (dis)ability. Attention should be paid to the nature of 'reproductive work' and career penalties for different groups, acknowledging additional prejudice (including around ART decisions) and bargaining power in the workplace. For example, consideration should be given to the extent that disabled employees already in receipt of workplace adjustments feel entitled to further ART-related accommodation, even where a policy exists. Scholars might explore the extent to which different ART-related policies and provisions influence job and career choices and/or mitigate career penalties, and conversely, how actual and anticipated ART-related career penalties impact ART-related decision-making, such as delaying or deciding against (further) treatment. This all adds to broader debates around the intersection between work and family-formation, such as those exploring the impact of certain occupational features on fertility, including stress or chemical exposure (see Younglai et al., 2005) and on decision-making around trying for children.

Conclusion

When it comes to the intersection between production and reproduction, the focus of both organisations and organisation studies scholars has been predominantly on pregnancy, maternity and parenting, neglecting pre-conception. Recent organisational interest in fertility-related benefits and provisions raises many questions, including around global winners and losers; the role of employers; and the private/public divide. For organisations, offering ART-related support may help in the 'war for talent', but there are costs and risks. For individuals, accessing ART is a privilege often linked to employment

positioning, which relates to reproductive stratification, but accessing ART might put an individual's career at risk, which at a broader level furthers gendered occupational stratification.

To unpick this, ART-related organisational support that is appropriate for only a certain type of worker (married heterosexual professional women) undergoing a certain type of fertility journey (achieving live birth on an early ART attempt, without significant mental health challenges) in a certain context (formal employment relationship in the Global North) exacerbates broader structural and cultural forces whereby 'some categories of people are empowered to nurture and reproduce, while others are disempowered' (Ginsburg and Rapp, 1995: 3). On the other hand, the very individuals who are empowered to access ART appear to experience negative career consequences for doing so.

When it comes to the rapidly evolving field of organisational interest in ART-related provisions, there is much more to learn about the impact on and perceptions of different stakeholders. We urge research approaches informed by intersectional political economy, and those that consider individual pathways of experience over time and in context (see Wilkinson, 2022) to explore the links between reproductive stratification and occupational stratification. Research is urgently needed on the intersection of ART and employment beyond the context of skilled jobs in the formal economy in the Global North. We also urge work that emphasises compassion-focused approaches (Mård, 2020) to organisational provision around employee fertility journeys, as opposed to business case logics, so that provisions adequately meet worker needs.

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Notes

1. Malta offers 100 hours' paid IVF leave (per cycle, up to three cycles) split between 'receiving person' and partner; Korea provides three days' leave per year (one paid) and protection from discrimination; and Japan has introduced provisions for public workers.
2. In this survey, 31% of those aged 18 to 34 believed fertility benefits should be offered by employers.
3. https://www.fertilityiq.com/topics/fertilityiq-data-and-notes/fertilityiq-workplace-index

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