COVID-19 AND THE EUROPEAN PARLIAMENT (POLICIES): A YEAR OF PERILOUS AD-HOC SOLUTIONS[1]

Milan BRGLEZ, Boštjan UDOVIČ and Amalija MAČEK[2]

The COVID-19 pandemic not only upturned people's way of life, but also exposed the lack of preparedness of states and supranational political institutions for such crises. The article assesses the policies of the European Parliament introduced over the last year to guarantee its functioning. What transpires is that, a year after the outbreak of COVID-19, EU institutions still act on an ad hoc basis, responding only to present challenges and not fostering resilience to unexpected crises in the long run.

Key words: COVID-19; European Union; European Parliament; governance.

1 INTRODUCTION AND PRESENTATION OF THE RESEARCH PROBLEM

The almost fairy-tale-like story of the European Union (EU) begins with the foundation of the Union as a community of countries wanting to prevent new wars and the possibility of warfare between different states on the European continent in general. Although initiatives for peaceful European unification, such as the Paneuropean Movement, can be found as early as the 1920s, far predating Winston Churchill's famous speech at the University of Zurich in 1946, in which he highlighted the pressing need for the creation of a united states of Europe, the formal basis for its foundation is commonly identified in the establishment of the European Coal and Steel Community in 1952. Five years later, the six countries of this European organisation also founded the European Atomic Energy Community (Euratom) and the European Economic Community. From then on, the European integration process proceeded with varying degrees of success.

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[2] **Milan BRGLEZ**, PhD, Centre of International Relations, Faculty of Social Sciences, University of Ljubljana, Member of European Parliament. Contact: milan@milanbrglez.si. **Boštjan UDOVIČ**, PhD, Centre of International Relations, Faculty of Social Sciences, University of Ljubljana. Contact: bostjan.udovic@fdv.uni-lj.si. **Amalija MAČEK**, PhD, Faculty of Arts, University of Ljubljana. Contact: amalija.macek@ff.uni-lj.si.

After the initial integration euphoria of the 1960s, enthusiasm somewhat cooled down in the 1970s. New impetus for the integration process came with the enlargement of 1981/1985 and the disintegration of the bipolar world system. Suddenly, several 'new' countries were vying for membership in the European Community. The core of the 'old' European Economic Community regarded them mainly through the lens of the Washington Consensus, which promoted free movement of capital. But because integration in Europe was also political, free movement of people was added to the free movement of capital. However, after the end of the Cold War, the newly emerging Europe did not experience any substantial change. With the exception of the common market, European integration—if it really may be called integration—was largely still intergovernmental, which was evident in the extremely complex procedures, as well as in the interdependence of the EU bodies, among which the Council had the strongest decision-making power, as it still does today. An additional attempt towards greater integration on the political level among the countries was the *Convention on the Future of the European Union*, sometimes also called the *European Convention*.[3] The document was supposed to answer the fundamental question on how EU member states, united in a common market, could also unite on a political level. The results of the Convention were recorded in a document known as the *Constitution for Europe*, which was never adopted since it was turned down in referenda in some of the member states. Soon after the great enlargement of 2004, the EU faced the first challenge of how to deepen the integration. Instead of the *Constitution for Europe*, which would have required serious changes to the structure of the EU, the member states decided to introduce only some amendments to the existing regulations, creating the Treaty of Lisbon.

This first political turmoil soon turned in empirical ones. First, a grave economic crisis hit the EU in 2008. EU institutions seemed to be incapacitated to act efficiently on the economic problems of EU member states. It took more than three years for the EU to agree on a single answer to possible future economic crises. While EU member states were trying to recover from the economic devastation on their own, the EU was hit by a second challenge—the migration crisis. This crisis revealed that the EU lacked the right instruments to deal with a large-scale influx of people escaping from wars and seeking asylum in Europe. Different approaches employed by EU institutions did not grant a stable and functioning solution, so again states were mostly on their own in finding a sustainable solution. During the migration crisis, the EU was subject to yet another shock, this time Brexit. Years ago, it seemed that the EU would only grow in size; Brexit on the other hand showed that member states can also decide to withdraw from the Union. This unprecedented occurrence not only shook the EU logic, but put on the table the main question that had remained unaddressed: How should the EU develop in the future?

COVID-19 was the third crisis facing the EU in the last decade. After its incapacity to solve the two previous crises was evident, it was expected that the EU would deliver better in the "healthcare crisis". But the expectations were not fulfilled. Now, a year into the pandemic, we are still stuck in the middle of this crisis. The

[3] *The Treaty establishing a Constitution for Europe* was based on the premise that the EU would become more integrated. Ironically, we should not forget that at the time the European Commission was represented in the Convention's Praesidium by Michel Barnier, the man who was appointed by the European Commission as chief negotiator for Brexit a few years ago and left this post in early March 2021. It should also be noted that another member of this Praesidium was Alojz Peterle, who later became a long-standing Member of the European Parliament.

different reactions from EU institutions and EU member states lead us to believe the EU does not address the COVID-19 crisis strategically but is rather more focused on day-to-day activities to mitigate the consequences.

The aim of this article is to evaluate the responses of EU institutions to the COVID-19 crisis, in our case the European Parliament. Why did we choose to analyse the European Parliament? Firstly, because it is the only EU body that is elected in direct elections in all 27 member states. This does not only make it the most democratic EU institution, but also gives it the highest responsibility to converge the differences within the EU into a single framework. And secondly, the European Parliament is the body that adopts EU legislation (together with the Council). As such, it should be the first in line to develop resilience to external shocks that could harm the legislative process.

In this article, we would like to answer the following two research questions:
R1: What were the characteristics of the response of the European Parliament to COVID-19 in the first wave (spring 2020)? Here we would like to analyse which measures were adopted, how these measures functioned, what problems arose from the introduction of ad hoc measures, etc. The idea of this analysis is to describe the context and activities taken by the European Parliament when confronted with COVID-19 issues. However, after the spring wave of COVID-19, the measures were relaxed by the summer of 2020. Since the European Parliament already had some experience with COVID-19 measures, etc., it would be logical that it would be prepared for the second wave of the pandemic (autumn/winter 2020/21).

This brings us to R2, where we will investigate whether the response of the European Parliament in the autumn/winter of 2020/21 shifted from ad hoc to strategic measures, and whether they had an internal and external logic.

The answers to the research questions will be sought using a set of different methods. The methods of critical analysis and synthesis of primary and secondary sources will set the framework for the research, while the empirical analysis of a case study of the European Parliament's response to COVID-19 will primarily be based on two methods: in-depth unstructured interviews with certain stakeholders involved in the processes within the European Parliament, and the participant observation method, which will provide us with some data and reactions to COVID-19 not available to the general public. Both methods will be combined to find answers to the research questions presented above.

The article is structured as follows: The introduction with a description of the research problem is followed by the theoretical part of the article, in which the basics of the EU's health policy are presented. This framework will then serve as a platform for the discussion on the measures adopted by the European Parliament on COVID-19. After the empirical analysis, the article wraps up with a discussion and conclusion, in which we provide answers to the research questions and outline possible areas for future investigation.

2 THE EUROPEAN UNION'S (A)SYSTEMIC APPROACH TO HEALTHCARE ISSUES

Taking into consideration the diversity of the European Union, especially its expansion and membership structure, it is clear that social and healthcare policy[4] could not become a Union policy. Firstly because of the historical legacy of each state in the area of social and healthcare protection and the development of different models, secondly because of ideological constraints—some countries are more protective in social and healthcare affairs, while others take a more liberal approach in these areas—and thirdly because social and healthcare affairs are an important part of the statecraft toolbox of each political elite. That is why it is also important that states retain as much power as possible in these areas. These three reasons explain the attitude of states and the EU towards social and healthcare policy. We could say that the situation today is a result of the needs and not the desires of states, since in the long history of European integration member states have realised that in the field of social and healthcare affairs at least some activities should be coordinated. In the gradual development of EU law, the coordination of activities between the EU and member states was euphemised as shared competences, a concept that is nowadays becoming more and more important (and in light of recent events—such as access to vaccines, etc.—also disputed; cf. Deutsch and Martuscelli 2020). In the area of healthcare, the EU and member states have shared competences (Treaty on the Functioning of the European Union 2007/2009, Article 4(k), Article 6(a)), which in fact means that the EU is a sort of platform, serving to coordinate policies if member states wish to do so.[5]

The problem of the formulation, development, perception and also application of healthcare policy in the EU was discussed by different researchers. Gerlinger and Urban (2007, 133ff) state that while officially healthcare policy is treated primarily as a national affair, it has been going through a dynamic process of Europeanisation, made possible especially by the open method of coordination (ibid., 140; Ruijter 2019). Greer (2009, 18–33) presents two frameworks for policy-making in the area of healthcare: one are the treaties (of the EU) and the other are the institutions. With respect to the treaties, Greer (ibid., 19) emphasises that the EU has weak competences in the field of healthcare, defined only in Article 168 of the TFEU (ex--Article 152 of the TEU).[6] According to his investigation, "the words 'complement' [paragraph 1] and 'encourage co-operation' [paragraph 2] are designed to emphasize that the EU may only supplement the work of member states, which are the main actors in health policy". Such criticism about the marginalisation of health policy at the EU level (ibid., 22) is repeated when presenting the main institutions related to healthcare, describing them as "complicated", and "able to create major problems for individual groups and member states if they have not influenced their policies" (ibid., 33). If this analysis is quite provoking, illustrating the complexity and inefficiency of the coordination between the EU and member states in the area of

[4] A symbolical reflection of the interconnectedness of health and social policy is also the EPSCO Council configuration (Employment, Social Policy, Health and Consumer Affairs).

[5] The main problem in the time of COVID-19 is that it is still impossible to evaluate whether the Union has gained more power in the system of shared competences, or it simply used the power it already had. Since the understanding of shared competences is blurred, both interpretations are possible. For the perception of the level of integration and competences of the Union vs member states, *cf*. Lovec (2020, 1096–1099).

[6] Apart from Article 168, the EU's competences in the area of public health are also defined in Article 191 of the TFEU (ex-Article 174), where "protecting human health" is second on the list of objectives to which "the Union policy on the environment shall contribute".

healthcare, a later investigation by Greer et al. (2014) presents the evolution of healthcare coordination at the EU level in a more positive light. As exposed in the conclusion of their discussion (ibid., 129), they note that the "EU has a surprisingly large impact on health, most of which comes from areas beyond the formal health article [Article 168, ex-Article 152]", but at the same time they point out that the EU health policy has two deficiencies: its fragmentation and its marginalisation. The healthcare policy of the EU is not central, but rather seems like a result of other policies (social policy, common market policy, etc.). If we disregard the treaties, which only deal with the health policies of the Union in two articles (Article 168 and Article 174), one cannot disagree with this comment. The observation of Greer et al. (2014) is implicitly confirmed also by the analysis of Gooijer (2007, xviii), who states that "the subsidiarity principle with regard to health care is slowly being eroded", but this cannot be understood as a unification, but more as a (coordinated) convergence at the level of quality and financial aspects.

This shows that the healthcare policy at the level of the EU can be perceived as both a blessing and a curse. A blessing in the sense of a common denominator (needs) reflected in shared competences, while the curse stems from the same framework—the coordination role—which limits the efficiency and effectiveness of the decision-making and delivery and can also lead to *beggar-thy-neighbour* policies, where individual member states' interests can prevail over communitarian ones (*cf*. Guy and Sauter 2016, 15).

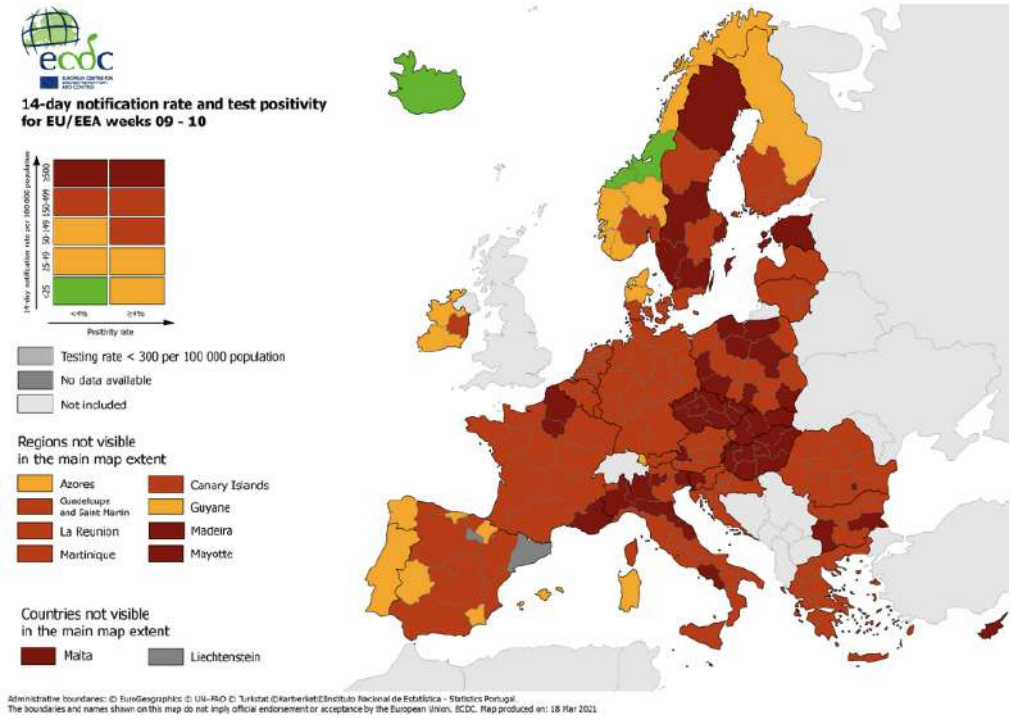
However, shared competences and long legislation procedures are not the only problem of healthcare policy at the Union level. As presented by Horgan and Kent (2017, 193), another problem is also the dispersion of healthcare authorities among the Council, the European Commission (there are different departments covering some areas of healthcare) and the European Parliament. They agree that such systemic failure (the absence of a clear chain of command) also hinders the efficiency of Union activities in the area of healthcare.

These embedded errors of the EU's decision-making system in healthcare were also visible particularly in the first wave of the COVID-19 pandemic, when all EU institutions acted with low level of coordination and no strategic approach on how to deal with the pandemic. Most of the activities of EU institutions were recommendations to member states on how to behave to avoid the spreading of COVID-19. And since recommendations are no more than that, member states were mostly left on their own. Consequently, they decided on the perilous issues as driven by their internal politics—some introduced harsher measures, while others went for softer approaches than recommended by EU institutions (Renda and Castro 2020).[7] The absence of a unified approach to dealing with COVID-related issues was visible in obtaining of data on those infected, deceased, etc. Renda and Castro (ibid., chapter IV) emphasise that the *European Centre for Disease Prevention and Control* (ECDC) has "competences to collect and share data" (on the infected, deceased, transmitted COVID-19 cases, etc.), but lacks the consistency and quality of data, since "not all countries are sharing data on the number of cases by age and sex", and key information such as test criteria, "which have a direct effect on the number of confirmed cases and deaths reported, was not fully shared". The problem of reporting came to the fore when the methodology for counting COVID-19 deaths became an issue since different countries across the EU adopted different methodologies for defining the statistic

[7] Slovenia's and Austria's closure of borders with Italy in March 2020 to stop the spread of COVID-19 was criticised by French President Emmanuel Macron (News18 2020).

(see The Conversation 2020). Another problem, exposed in the autumn and winter of 2020/21, was the illustration of the spread of the virus in different countries. The EU adopted a colour map of infection rates in a country, but since the colour code criteria were developed in relatively good times (spring 2020), at a certain point all EU member states were categorised as red or most problematic. That is why the EU added to a "dark red" category to the table, to be used for the most problematic areas. But as it seems from Figure 1,[8] this methodology has not helped develop a uniform answer to COVID-19 threats.

FIGURE 1: 14-DAY TEST POSITIVITY FOR THE EU/EEA IN WEEKS 9–10 OF 2021



Source: ECDC (2021b).

The theoretical framework presented three problematic points of healthcare policy in the EU. Firstly, although healthcare policy is still part of shared competences, it is becoming more and more intensively coordinated. This was in one part incentivised by the decisions of the European Court of Justice,[9] while on the other hand also by the needs of member states, which are giving the EU a larger proportion of decision-making on health—mostly indirectly (under Regulations 883/04 and 987/09 and Directive 2011/24). Secondly, healthcare policies at the level of the EU are still perceived as an additional activity, not a central one. This is reflected also symbolically, since dealing with health issues at the EU level is not centralised or unified but dispersed among different dossiers and different bodies have the authority to decide on health affairs (e.g., the Council, the European Parliament). Thirdly, COVID-19 revealed that the complexity of healthcare issues requires intensified action of the EU in the field of healthcare. This can be achieved directly, by changing the basic treaties, or indirectly through practice (see also van Schaik and van de Pas 2020). The process of implicitness and indirectness has proved in the past to be more fruitful than direct, top-down decisions. Deeper integration in healthcare affairs is on the

[8] For the definition of other zones, see ECDC (2021b).
[9] On the role of case law, see Bessa Vilela and Brezovnik (2018).

table, since states need it. The main task for the EU is to deliver quick decisions. Here the main obstacle is the structure of the decision-making process.

3 COVID-19 AND THE EUROPEAN PARLIAMENT: AN EMPIRICAL ANALYSIS

3.1 Introduction

At the dawn of 2020 it did not seem that COVID-19 could pose a serious threat to developed countries. Since the outbreak of COVID-19 occurred in China, it was expected that it would harm especially Eastern Asia and African countries (Raga and te Velde 2020, 8), while Western (developed) countries were perceived to be less under threat. It is clear from this presumption that analysts based their predictions on lessons learnt from the cases of SARS (Severe Acute Respiratory Syndrome, 2003) and Avian influenza (1997 in Thailand, 2013 in China). But the COVID-19 situation was different. Firstly, because COVID-19 has turned out to be much more contagious; secondly, the world is more globalised comparing to the early 2000s and even to 2013, meaning that the virus can spread faster. Contrary to the expectations, the EU had its first COVID-19 patients by mid-January 2020. At that point the debate started that some pre-emptive action should be taken to limit the spread of the virus in the EU. There were different views on what to do—limiting air traffic between the EU and Wuhan or China in general, introducing quarantine for people arriving from China (regardless of citizenship, etc.). A lack of a unified or even coordinated approach in the EU (member states were introducing measures on different levels) convinced Slovenian Member of the European Parliament (MEP) Milan Brglez to address a written question to the Council (23 January 2020),[10] asking about possible EU action to prevent the spread of the virus:

An increase in the number of deaths (17) resulting from the recent outbreak of the new coronavirus in Wuhan, China has been recently reported. The Platform for European Preparedness Against (Re-)emerging Epidemics (PREPARE) has voiced concerns about the credible threat of a pandemic in Europe. The UK, France and Italy have direct flight connections to the region of Wuhan, where the virus originated, and Austria has direct flight connections to other Chinese regions. Some airports have already adopted measures to stop the virus being spread by passengers arriving from China. However, there are suspicions that the passenger screening process might not be fully effective. The fact that large numbers of people are currently in transit for the Chinese New Year period is a cause for concern.

With a view to fulfilling the provisions laid down in key legally binding documents and protecting the lives of EU citizens by guaranteeing healthy environmental conditions, does the Council expect that it will be necessary to coordinate adequate preventive measures among the most at-risk airports in the Member States in order to stop the virus spreading in the EU?

Although it would be expected that the Council would respond to this issue as soon as possible, it took almost three months to answer. On 16 April 2020, Brglez received a reply that was bureaucratically dry and opened with this passage:

[10] There were some remarks that Brglez addressed the question to the wrong EU institution, and that the question should be raised with the European Commission.

It should be noted that competence to take preventive health measures on serious cross-border threats lies with the Member States (Council Reply P-000510/2020) […]

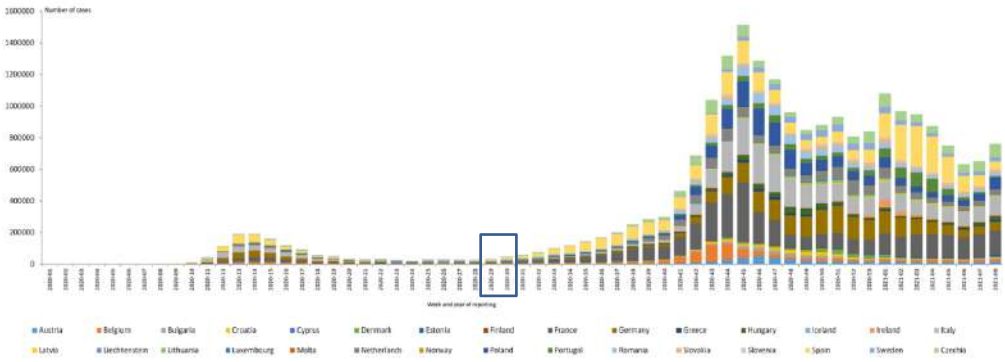
It continued in the same manner:

Member States, in accordance with Article 11 of Decision No 1082/2013/EU, are consulting each other within the Health Security Committee (HSC) and liaising with the Commission with a view to coordinating their national measures.

Then the text listed all the activities that the Council undertook to mitigate the COVID-19 crisis (meetings of the Council, meetings of the Council and the European Council, etc.). Apart from the administrative dryness, the answer also shows that the EU sticks to its coordination role. When COVID-19 was spreading among member states, the EU tried to find a joint solution "by coordinating". This is confirmed also if we analyse the webpage of EPSCO (Employment, Social Policy, Health and Consumer Affairs Council), which shows many meetings of health ministers,[11] but with little impact. What also transpires when analysing the official statements of the Council is that the EU realised that it underestimated the problem of COVID-19. Although Croatian Health Minister Vili Beroš claimed on 13 February 2020 that the response of the EU was "prompt and effective", he revised his stance somewhat after the 6 March 2020 EPSCO meeting, saying that "[p]rotecting public health is *our top priority*", and that "[t]he EU's response to the outbreak […] *has been very good, but the situation has changed"* (emphasis added) (Beroš 2020).

In April 2020, slowly, the crisis began to subside somewhat, and by-mid May 2020 it was clear that the situation in the EU was improving, but COVID-19 would remain a serious threat throughout the year. A short relief followed in the summer, but already in August 2020 some signs of a possible second (and harsher) wave of COVID-19 were already visible (see Figure 2 from week 29 on).

FIGURE 2: NUMBER OF COVID-19 CASES (1 JANUARY 2020 – 1 MARCH 2021); BY WEEK



Source: ECDC (2021a).

The first wave demonstrated two things for which the EU (and its institutions) should be prepared in the second wave. Firstly, coordination of approaches is not enough. What should be done is that the European Commission should shift from a coordinating role to a leading role. Here member states would have embraced

[11] EPSCO held meetings on COVID-19 on 13 February and 6 March 2020, after which the health ministers held videoconferences on 15 April, 5 May, 12 May, 9 June and 12 June 2020 (Council 2020).

the possibility of a joint approach, granting higher stability and predictability. The European Commission did this with vaccines, but we should take into consideration that there it had more room for manoeuvre there. It is true that the European Commission coordinated or led the public procurement for vaccines, but on the other hand it also allowed member states to decide which and how many vaccines they would order. However, if the European Commission acted more proactively and (maybe) beyond its authority, the vaccination policy and related issues would be better coordinated and there would be less possibility for solo actions, as we are now seeing from different member states. Secondly, EU institutions should prepare a backup plan for such situations to enhance resilience, not only via member states, but also in terms of their internal tasks. If the first wave of COVID-19 hit the EU unprepared and the decisions about the working processes were developed ad hoc, the internal structure could/should be more solid when the second wave came, worker protection should be at a higher-level, while at the same time the new normal should not harm the procedures within EU institutions.

3.2 The European Parliament's response to COVID-19: three case studies

The European Parliament (EP) responded to the looming threat of COVID-19 relatively late. MEPs received the first notification of EP authorities on COVID-19 on 26 February 2020 (Quaestor Notice 09/2020).[12] The notification listed all the areas where COVID-19 had already widely spread (China, Singapore, South Korea, Iran, northern Italy). The MEPs were given two recommendations in the event they had been in any of the abovementioned areas prior to that date:[13]

A. If you are well and you had no (suspected) contact with a person infected with the novel Corona virus, COVID-19:

- *stay home in self-isolation and do not come to the EP (also not to the Medical Service); you can use the IT tools provided by the European Parliament to be in contact with your office;*
- *monitor your health/take your temperature twice daily for 14 days; if you develop any symptoms, please refer to section B below;*
- *if after 14 days of your return, you have no symptoms, you are advised to visit your General Practitioner to receive a full clearance.*

B. In case you had any known or suspected contact with a person infected with the novel Corona virus COVID-19, or if you develop any symptoms: […]

- *Please contact your General Practitioner for urgent advice and care. If you are in Brussels and you do not have a GP here, you can find one by calling 02/212 22 22. Doctors on call: http://www.gbbw.be/index.php/en/*
- *In case of medical emergency, call 112.*
- *Always inform the caregiver about your recent travel history and do not go the clinic without prior telephone contact. (When in a clinic, ask to wait in a separate room; do not stay in a waiting room with other people.)*
- *Do not come to the office until you have received a green light from a General Practitioner.*

These instructions were ("strongly") recommended to MEPs, however problems arose because a number of MEPs arrived from Italy or flew through northern

[12] The *Quaestors* are a group of MEPs elected for supervising administrative and financial matters related to the work of MEPs, or to supervise other activities as decided by the *Bureau of the European Parliament*.

[13] Emphasis by the European Parliament.

Italy. Some of them insisted they were healthy, so they could not be ordered to remain in quarantine at home.[14] On 2 March 2020, the President of the EP adopted the decision of cancelling all missions and delegations of MEPs, as well as all ancillary events at the EP and all external visitors of EP meetings (e.g., the interested public). "Unless otherwise specified […] the governing bodies of Parliament, plenary, ordinary and extraordinary committee meetings, and the political groups *shall not be restricted in their ability to function normally […].* Media representatives *shall not be excluded from accessing Parliament's premises* unless so required by Article 2" (CP D(2020)9024).[15]

On 5 March 2020 (Quaestor Notice 12/2020), the European Parliament closed sport facilities used by its staff;[16] a day later, on 6 March, all visits to the European Parliament were cancelled until 23 March 2020 (Questor Notice 13/2020).[17] On 9 March the President of the EP ordered social distancing among members, instructing that "(a) *the attendees do not approach each other closer than 1 meter when seated*, (b) attendees shall *avoid direct physical contact* such as handshakes, (c) persons showing symptoms of respiratory illness such as sneezing, running nose or cough shall not attend the meeting" (emphasis added), and telework, i.e. remote collaboration between MEPs (CP D(2020)9886). On 11 March 2020, the Secretary-General of the EP adopted a protocol for the event of an infection of a MEP or staff member (Quaestor Notice 18/2020) and ordered the approval of 100% telework on request[18] and 70% telework "*for all staff* whose physical presence in Parliament is not absolutely indispensable".[19] The Quaestors also *recommended* (emphasis added) the same for accredited parliamentary assistants (APA) and trainees working at MEPs' offices (Quaestor Notice 20/2020).[20]

Case study 1: The position of APAs, local assistants and trainees

By the end of March 2020, all missions of APAs and trainees planned for 2020 were cancelled. Furthermore, the EP temporarily suspended the recruitment of APAs, local assistants and trainees (Quaestor Notice 23/2020). Consequently, several individuals were left without a contract, and a number of trainees whose contracts expired at the end of March or in April were also left in the air. The right to employ APAs and trainees was re-established only one month later (Quaestor Notice 25/2020), but this was already too late for all those who had booked transportation or cancelled accommodation. But this was only the beginning of confusion. The main problem with the adoption of measures was their lack of predictability. This became an issue in the case of APAs, who had mixed instructions, depending on their MEP. Quaestor Notice 20/2020 advised MEPs to treat APAs in the same way they treat other EP staff, meaning that they should enhance the teleworking of their APAs. Some MEPs decided that because of the problematic situation in Brussels they would allow their APAs to go to their countries of origin and continue to work (remotely) from there, while other MEPs argued that teleworking meant teleworking from Brussels. Due to lack of clear

[14] Data acquired through the authors' observation and conversations with the MEPs.
[15] Emphasis by the EP.
[16] Belgium closed sport facilities at midnight on 14 March.
[17] The prediction that the European Parliament would only remain closed to visitors for three weeks proved unrealistic.
[18] Employees eligible for the approval of telework were pregnant women, people over the age of 60 and people with chronic illnesses.
[19] The measure entered into force on 16 March 2020.
[20] Here we need to draw attention to the following passage, the wording of which caused a number of problems: "Members are recommended to apply the same measures mentioned above with regard to their Accredited Parliamentary Assistants (APAs) and other staff, including trainees."

instructions, some APAs left Belgium, which soon became a problem. This is seen from the Communication of Directorate General for Personnel (DG PERS) issued on 3 April 2020, saying:

According to the Staff Regulations and the Implementing Measures for the Assistants' statute, the possible places of work are limited to Brussels, Luxembourg and Strasbourg [...]. [T]elework must be performed from the address that the Member of staff has communicated to the administration of the Parliament pursuant to Article 20 of the Staff Regulations, i.e. their address in their place of employment.

This DG PERS communication caused a serious problem, since some people had already left Belgium and faced the threat of losing their contract or part of their salary. After this communication of DG PERS was issued, part of the MEPs strongly opposed such interpretation of the rules set in the *Staff Regulations*, claiming that telework could be done wherever and that such interpretation was just an administrative burden. Not only emails were circulating daily, some APAs and trainees—even though it was almost impossible to travel—used different means of transportation (exposing themselves to grave health risks) to come back to Brussels. A group of representatives of APAs held a meeting on 7 April 2020 with the Director-General of DG PERS (APA Committee 2020) in order to solve the misunderstanding, but were unsuccessful, since DG PERS insisted that according to existing rules APAs could only telework from their places of employment, while other possibilities were in hands of the Bureau of the European Parliament. The Bureau met on 17 April 2020. Instead of adopting a single solution, it decided that the "justification" of absence would be judged on a case-to-case basis (Pereira Silva 2020).

The calming of the first wave of the COVID-19 pandemic put on the table the issue of the European Parliament resuming normal work. APAs were able to work from the office by June 2020 and throughout the summer of 2020. Since the European Parliament had already faced issues during the spring 2020 lockdown, one would expect it to be better prepared for the autumn/winter of 2020/21. While the measures adopted may have been somewhat more structured compared to the spring of 2020, they were still incoherent. One such measure, based on the criteria of leverage, was presented in Quaestor Notice 55/2020 (4 October 2020). After a long introduction analysing which measures introduced by the European Parliament were not respected, a new measure of "one person per room" was introduced. Two weeks later, on 20 October 2020, the number of people able to work in the premises of the European Parliament decreased from 1 per room to 1 per MEP (Quaestor Notice 59/2020). The European Parliament also emphasised that "[r]andom checks will be performed by Parliament responsible services to ensure compliance with the provisions set in the President's decision". This measure is still in force today, six months after its introduction.[21]

Case study 2: Interpreters and interpreting in the European Parliament

The European Union has the largest interpreting service in the world. At the beginning, 4 languages of the founding states (French, German, Italian and Dutch) were used, among which 12 language combinations were possible. Today, there are 552 combinations. EU institutions have their own internal interpreting

[21] The check at the entrance to the European Parliament does not allow more than one person per MEP to be in the European Parliament at the same time. This causes serious problems during plenaries when staff need to switch (one has to leave the building before the other can enter), while the process of traineeship is also becoming near impossible.

services, in which a relatively small number of interpreters for each language are employed. There are around 800 full-time interpreters for all languages (employment requirements are extremely strict) and around 3,000 contract interpreters working for the institutions. COVID-19 mainly affected freelance interpreters (ACI) who remained without work and without an income overnight. To be precise, contract sums were paid until the end of May 2020 (regardless of whether interpreters actually worked on the day planned a year before), but from June on their situation became even more difficult, as for the first time in history the European Parliament and Commission cancelled interpreting contracts until the end of 2020. In the first stage, when the European Parliament sessions were still held remotely, some meetings were not interpreted in all languages, and MEPs were forced to use the "big 6". In the autumn/winter of 2020 the situation improved a bit and MEPs officially regained the possibility to deliver their contributions in their own language, but in practice this was still a problem, since interpretation was not always granted for smaller nations/languages. That is why the 8 Slovenian MEPs wrote a letter to EP President David M. Sassoli on 15 September 2020 stressing that the European Parliament was obligated to ensure that MEPs can deliver speeches in their own language, not only because this is set down in the *Rules of Procedure*, but also because neglecting some languages can create a perception of inequality among member states.

On the private market, the use of remote simultaneous interpreting (RSI) through interpreting platforms became a new reality. EU institutions hesitated, especially because of working conditions and data security. The ad hoc character and the challenges related to the interpretation issues ended in April 2021 when the global association of interpreters (AIIC) and the EP reached an agreement on interpreting via e-platforms, which is going to be established in due time.

Case study 3: A break away from the Conclusions of the Edinburgh European Council

We have already shown that COVID-19 had a severe impact on the procedures of the European Parliament, but what has remained in the background is that COVID-19 also led to the abolition of certain untouchable practices. One such practice was the European Parliament plenary sessions held in Strasbourg 12 times a year. This is not just a practice but is part of the Conclusions of the Edinburgh European Council and was respected until March 2020.

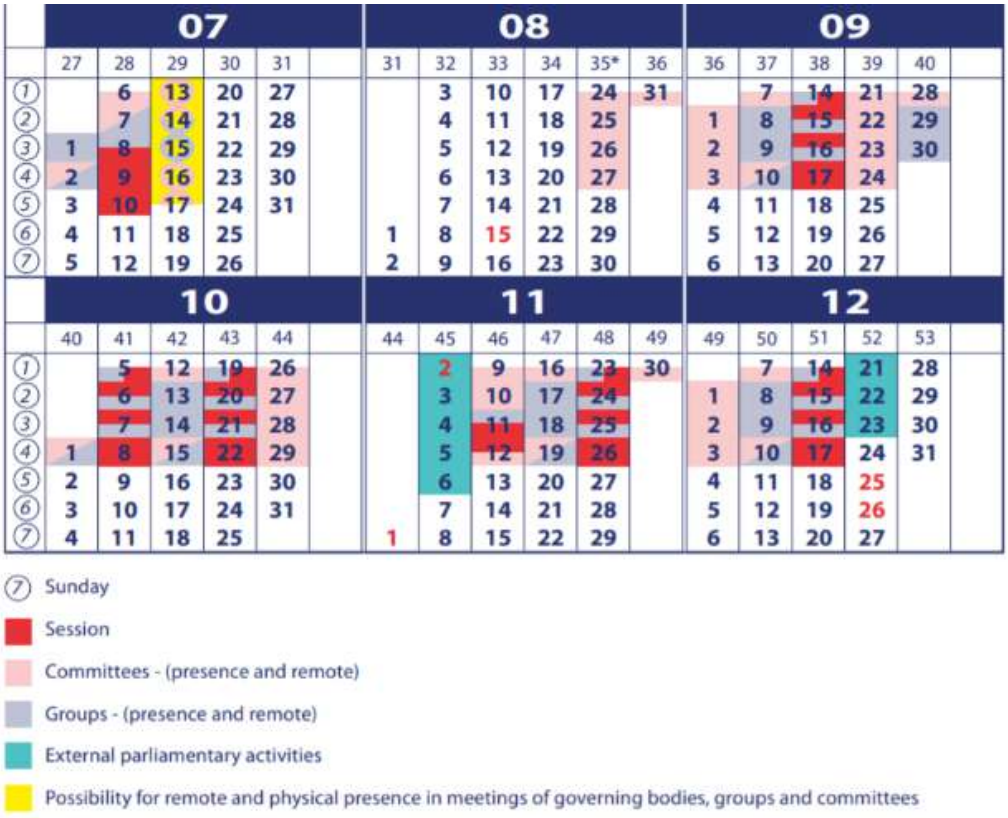
With respect to the European Parliament, the Edinburgh European Council Conclusions of the Presidency from 11 and 12 December 1992 (SN/456/1/92) were important for two reasons. The first was a change in the number of seats in the EP (because of the unification of Germany in 1989), and the second was a clear definition of the (main) seats of EU institutions. Article 1 of Annex 6 thus says:

The European Parliament shall have its seat in Strasbourg where the twelve periods of monthly plenary sessions, including the budget session, shall be held. The periods of additional plenary sessions shall be held in Brussels. The Committees of the European Parliament shall meet in Brussels. The General Secretariat of the European Parliament and its departments shall remain in Luxembourg.

The excerpt above clearly states that the plenary sessions (12 a year) need to be held in Strasbourg (called the "big plenaries" because they last four days), while additional plenary sessions (known as "small plenaries" because they only last

one day) take place in Brussels. However, after the outbreak of COVID-19, the European Parliament had to decide what to do. A decision on the plenary session in Strasbourg planned for March 2020 was first postponed until it became clear that it would be impossible to hold there as normally. First, only the March 2020 session was moved to Brussels, which was presented as a provisional measure, while Quaestor Notice 21/2020 (dated 11 March 2020) set a precedent for the functioning of the European Parliament: plenary meetings in Strasbourg scheduled to take place monthly until September 2020 were cancelled. Instead of Strasbourg, the meetings were moved to Brussels and shortened. The situation was repeated in the autumn/winter of 2020 and continues in the spring of 2021.

FIGURE 3: NEW PLENARIES FOR 2020



Source: European Parliament (2021).

4 DISCUSSION AND CONCLUSION

The article addressed the issue of the impact of COVID-19 on the functioning of EU institutions, in particular the European Parliament. Since COVID-19 is a healthcare issue, we also tried to develop a theoretical framework for a discussion on how shared competences can hinder the ability to cope with challenges, since both parties can play a two-level game when unwilling/unable to take responsibility in a crisis. From our analysis, we can draw the following three issues that should be studied in further detail.

Firstly, shared competences can prove to be inefficient in a time of crisis. In normal routine conditions, shared competences can work and may even provide better results than a top-down approach. But in a time of crisis, time and efficiency are of utmost importance—delivering the best solutions as soon as

possible. In such context, shared competences can become not only an obstacle, but can seriously harm the activities and the decision-making process(es). In the case of COVID-19, the EU lost its opportunity to develop itself as a relevant actor in healthcare issues. There were some attempts, but what it lacked (and this is also confirmed by some top EU decision-makers; see Herszenhorn and Deutsch 2021) was an estimation of challenges and opportunities of how the EU could be an important player also in areas of shared competences.

Secondly, the COVID-19 pandemic confirmed that the shared competences in the field of healthcare need rethinking. This is especially visible in the procurement of vaccines, where the EU as an actor can achieve more compared to each individual state. But at the same time, the story with the vaccines has also made it clear that EU institutions (such as the European Medicines Agency—EMA) can decelerate the efficiency of vaccine delivery. The EU can therefore be both an accelerator and decelerator of efficiency and appropriate response. This means that EU institutions should invest more in diminishing the barriers while enhancing the advantages. The COVID-19 pandemic is a healthcare crisis that caught the EU unprepared, but it is probably not the last one. The EU should rethink already today its positions and procedures in order to develop more resilience and a more effective approach in reacting to threats coming from its surroundings.

Thirdly, the three case studies from the European Parliament show that the EU should invest more in its internal resilience to unexpected events. What the three case studies make clear is that the European Parliament was completely unprepared for such a crisis in the first wave, but it could also have reacted better or with more structured measures in the second. It is true that the situation is getting better every week, but on the other hand such important and large institutions should have contingency plans for reacting to possible threats and at the same time preserving their modes of operation (not breaching the practices and EU law—e.g. the Edinburgh European Council Conclusions), avoiding misinterpretations (as in the case of the APAs) and finally, developing plans to decrease the possibility of diminishing rights of each employee or MEPs and also their states of origin.

Answering the research questions, we can say that the response of the European Parliament to challenges in the first wave of the COVID-19 pandemic was based on ad hoc solutions, sometimes the messages/actions were confusing, causing serious personal problems for EP staff. Since they were unprepared, the reactions were sometimes also abrupt, although logical. However, the experiences form the first wave meant that during the second wave some activities were performed in a more structured way, the measures adopted had an inherent internal logic, but there is still room for improvement. A year after COVID-19 hit Europe, MEPs still vote according to the classical system of printing the ballot, marking their vote, and then scanning and sending it to Brussels by email. Here, a step forward is needed.

Finally, the COVID-19 pandemic is quite a hard lesson for the functioning of the European Union. All the sceptics that had been presenting the EU as outdated understood that the vitality of an international institution is most relevant in a time of crisis. We agree that the EU has its own problems, but the COVID-19 pandemic has shown that the EU is not just an integration for good times—it is even more relevant in bad times. With all of its problems, it provided a platform for the development of COVID-19 vaccines in less than a year, it organised the

procurement of necessary equipment, it adopted a large recovery package, etc. All these activities, most of which are based on a win-win approach, would vanish if we opted to return to individual states. Because instead of cooperation the policy of beggar thy neighbour would prevail. We know as much from many historical examples.

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DELOVANJE EVROPSKEGA PARLAMENTA V PRVEM IN DRUGEM VALU COVID-19: POMLAD – ZIMA 2020

Covid-19 ni samo spremenil življenja ljudi, ampak je razgalil tudi (ne)pripravljenost držav in mednarodnih organizacij ter institucij na nenadne (zdravstvene) krize. Članek se osredotoča na dileme/probleme, s katerimi se je moral spopasti Evropski parlament v prvem in drugem valu covid-19, spomladi in jeseni 2020. Analiza pokaže, da kot druge institucije tudi Evropski parlament ni bil pripravljen na krizo takih razsežnosti, zato so bili v prvem, delno tudi v drugem valu covid-19 njegovi ukrepi namenjeni predvsem reševanju aktualnega stanja, niso pa bili zastavljeni dolgoročno.

Ključne besede: covid-19; Evropska unija; Evropski parlament; vladanje; upravljanje.