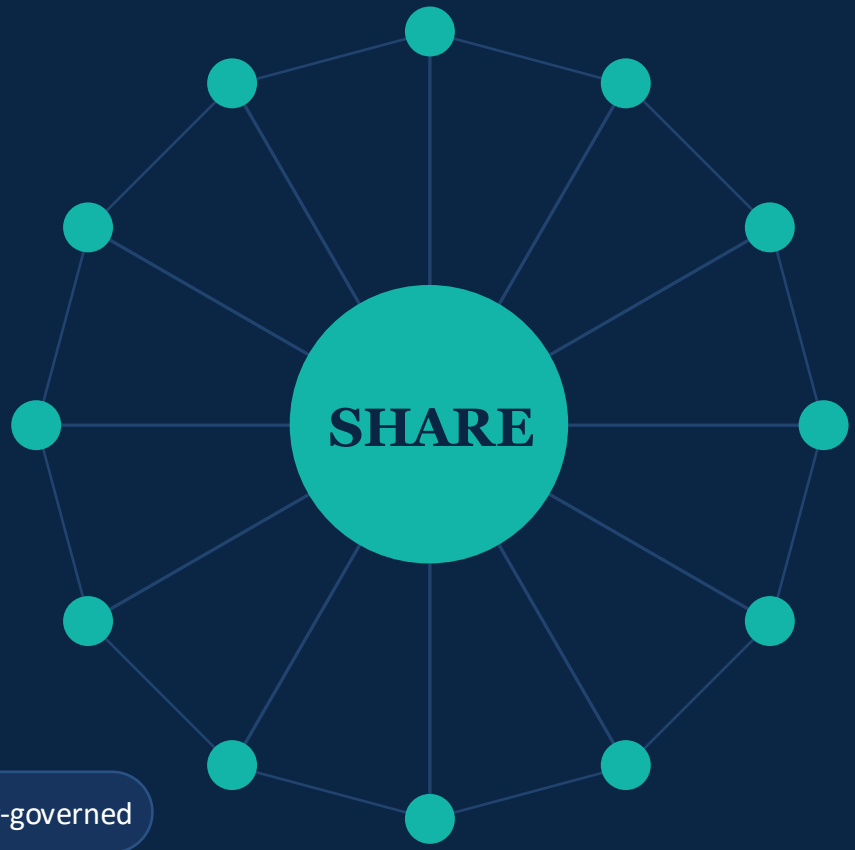
PRESENTATION TO THE BELGIAN HEALTHCARE COMMUNITY · OCTOBER 2026

SHARE

Shared Health Analytics & Research Ecosystem

One national health-data ecosystem, built by care providers, for every care provider



Open to all care providers

Data stays at the source

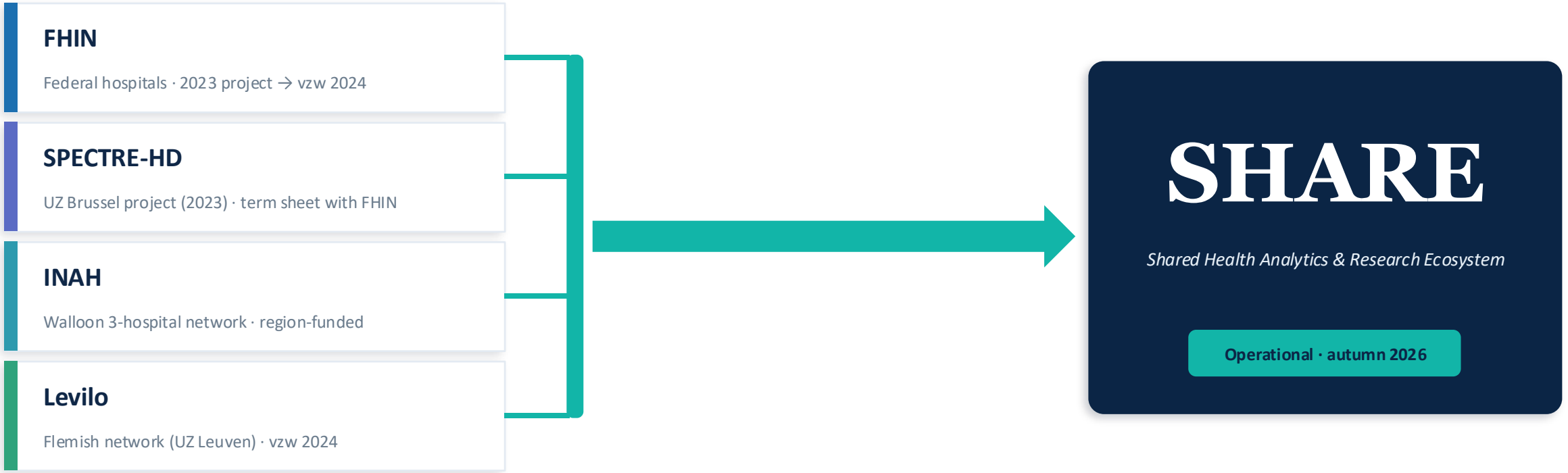
The HDAB decides

Member-governed

THE BELGIAN HEALTH-DATA LANDSCAPE

Four networks. One national platform.

2023–2026: consolidating Belgium's fragmented hospital-data networks into SHARE vzw





WHY NOW

Every care provider becomes a data holder

Regulation (EU) 2025/327 sets fixed dates for secondary use. Each data holder must describe its datasets and deliver data under HDAB permits.

26 Mar 2025
EHDS enters into force

Oct 2026
Today · SHARE becomes operational (autumn 2026?)

26 Mar 2029
Key secondary-use duties apply: HDABs, dataset descriptions, data under permit, secure processing environments

26 Mar 2031
Remaining data categories follow

Each provider on its own

- Builds and maintains its own data model according SHARE standard
- Follows SHARE standard which in turn allows SHARE query reuse
- Handles the federated client itself

Together in SHARE

- Align once to one common standard
- Catalogue metadata generated and maintained for you
- Shared request execution and secure processing environment

THE STARTING FOOTPRINT

National scale. Federated by design

SHARE starts from 20+ Belgian hospitals in all three communities, and is open to every care provider that generates health data.

20+
founding hospitals

6
university hospitals

3
communities — national coverage

1
shared standard instead of 20+ separate builds

National real-world evidence

Query a federated footprint across Belgian care providers. Data stays at the source; analysis runs inside a secure processing environment.

Faster feasibility and trials

Size cohorts and locate sites nationwide in one request, shortening feasibility and recruitment for multi-site studies.

Shared infrastructure, shared cost

Care providers align once to the SHARE standard instead of each building catalogues, pipelines and secure environments.

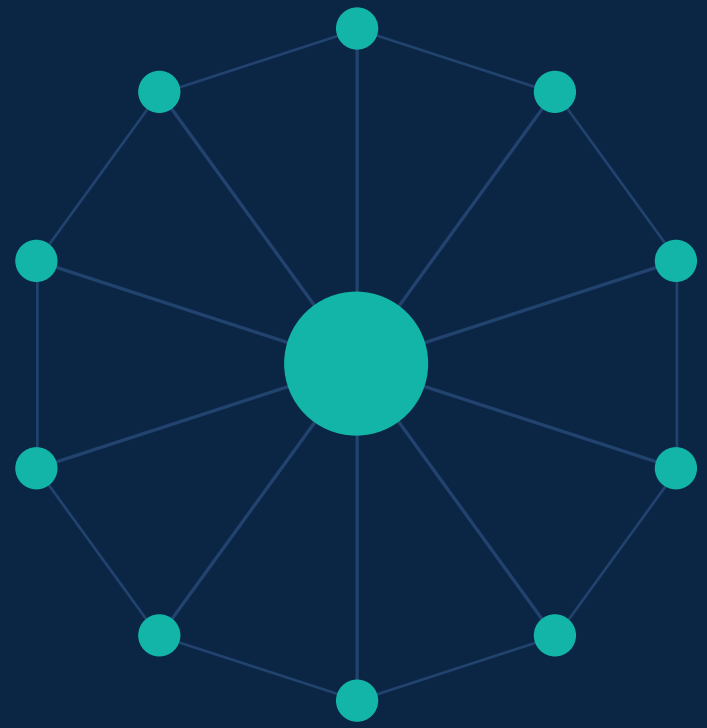
FIRST FLAGSHIP PROJECT · PROOF OF CAPABILITY

Cardiac amyloidosis (ATTR-CM): validating, retraining and extending an ECG foundation model across participating members to find undiagnosed patients.

01

What SHARE will do

A shared, provider-side infrastructure for the secondary use of health data, in line with the EHDS.



OUR ROLE IN THE EHDS

SHARE sits between data holders and the HDAB

SHARE acts as Health Data Intermediation Entity (HDIE) for its members. It executes; it does not decide on access.

Data holders
Care providers · SHARE members

- Keep source systems and local OMOP under their own control
- Maintain source-to-OMOP mappings according SHARE standard
- Check and release each data extract

SHARE vzw
Health Data Intermediation Entity

- One OMOP profile, vocabulary and mapping rules for all
- Generates and maintains catalogue metadata
- Runs federated retrieval for approved requests
- Operates the secure processing environment

HDA / HDAB
Belgian Health Data Agency

- Maintains the national catalogue
- Assesses data access applications
- Issues or refuses the data permit
- Governs access to the secure environment

Data users
Researchers, public bodies, innovators

- Find datasets in the national catalogue
- Apply to the HDAB
- Analyse inside the secure environment; only anonymised results leave

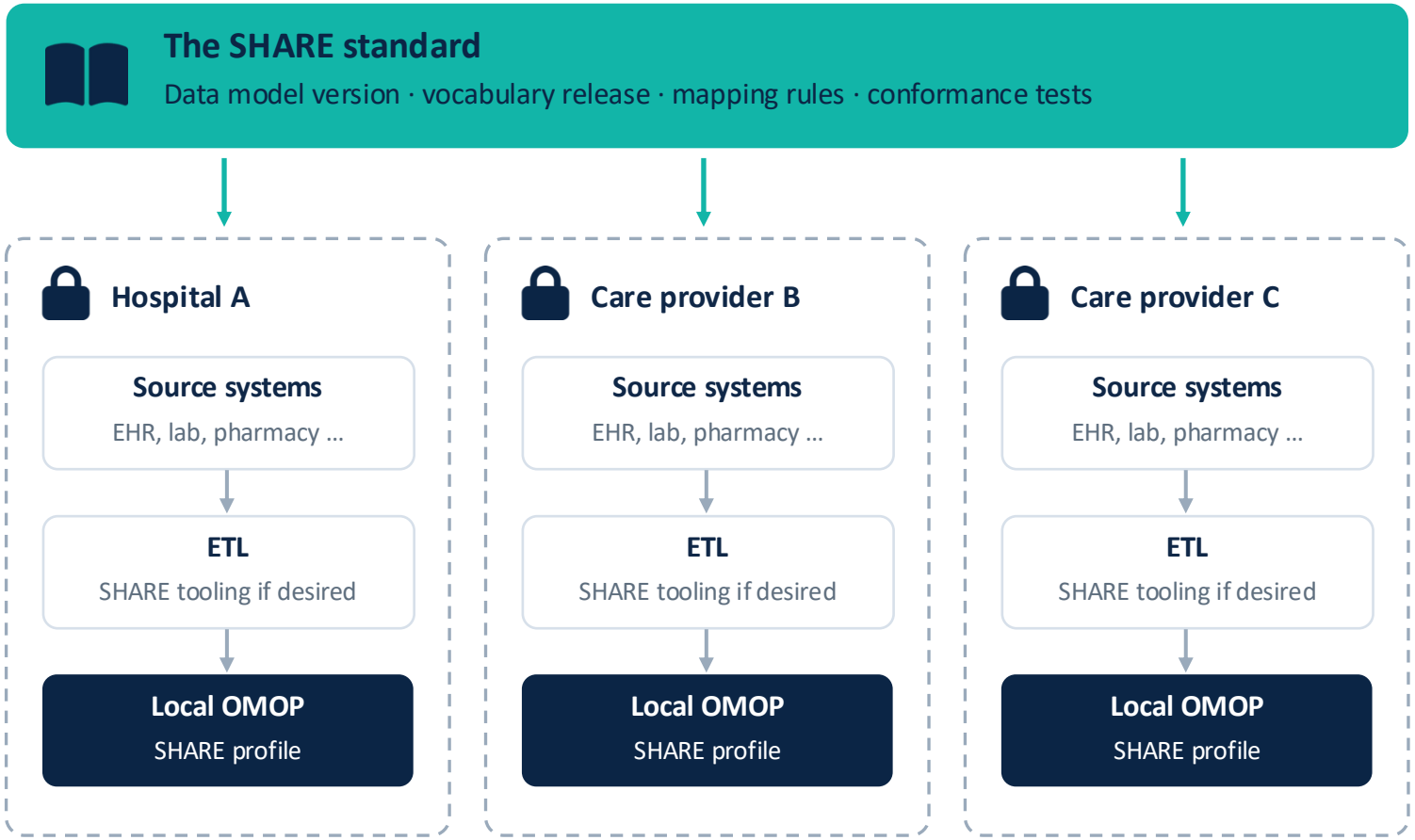
The HDAB decides. SHARE executes. The data holder stays in control.

EHDS art. 50(3): Belgian law may let an intermediation entity fulfil data-holder duties; formal designations may still evolve before 2029. SHARE does not take the HDAB role (statutes art. 27).

STANDARDISATION AT THE SOURCE

One data model, installed at every data holder

Patient-level data does not leave the data holder. SHARE brings the standard to the data, not the data to SHARE.



Dashed line = the data holder's own infrastructure (on premises or its own cloud tenant).

Why one standard matters

Same query, same meaning

A validated query means the same at every site.

One catalogue extractor

Identical code generates every member's metadata.

Central maintenance

SHARE updates mappings and vocabularies once; members apply them locally.

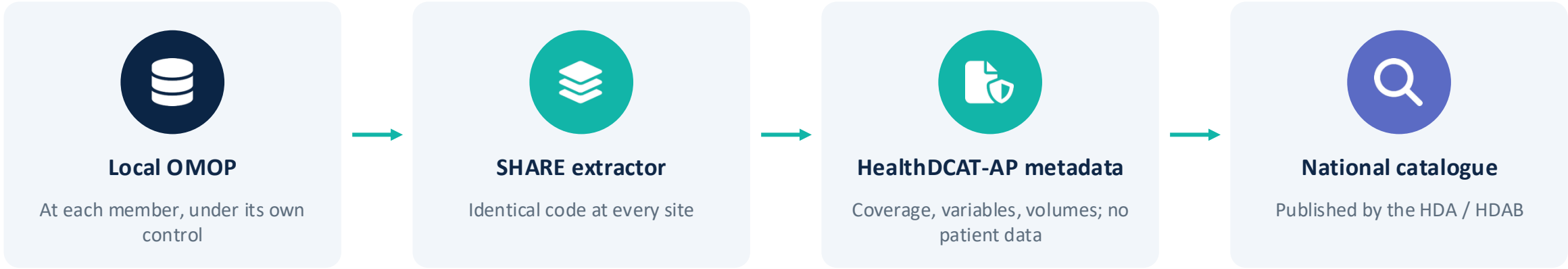
Model-agnostic principle

OMOP is the starting choice; the principle holds for any common data model.

DATA CATALOGUE

Align once, and your catalogue stays current

One common extractor turns each local OMOP database into a standard dataset description. Before a permit, only metadata leave the data holder.



No in-house catalogue team needed

Members that follow the SHARE standard get their dataset descriptions generated and submitted for them.

Always current

Metadata are regenerated with each data refresh, so the catalogue reflects what is really there.

EHDS duty covered

From 2029 every data holder must provide dataset descriptions to the HDAB. SHARE does this on the member's behalf.

FROM QUESTION TO ANSWER

One decision path, one technical execution path

Data holder · SHARE · HDAB · Data user · = approval gate

1 Local data layer

Sources mapped to the local SHARE OMOP

Data holder · SHARE

2 Catalogue

Metadata generated and published nationally

SHARE

3 Application

User finds data and applies to the HDAB

Data user

4 Permit

Legal and procedural assessment; permit issued or refused

HDAB

5 Federated query

One query to the relevant sites; each data holder releases its extract

SHARE · Data holder

6 Preparation

Quality check, minimisation, pseudonymisation as the permit requires

SHARE

7 Secure analysis

Work inside the SHARE SPE; only permitted anonymised outputs leave

Data user · SHARE

8 Cross-border

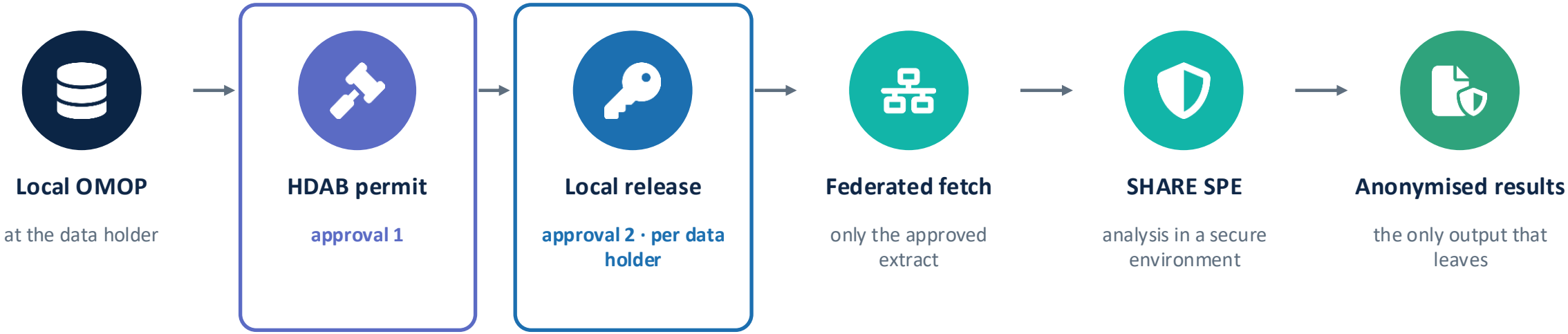
Via HealthData@EU, connected by the HDAB, where applicable

HDAB

TRUST BY DESIGN

No data moves without two explicit approvals

Data are gathered through a federated platform. Each data holder shares only what an approved request covers, and only after its own release.



Scope-limited

Only the data points, period and population the permit describes are queried.

Data holder in the loop

Each data holder checks and releases its own extract before the federated platform fetches it.

Fully logged

Mappings, query versions, site executions, releases and SPE activity are recorded and reproducible.

PROPOSAL UNDER DISCUSSION

Not yet agreed

A faster route for SHARE-based requests

The idea: SHARE prepares the assessment, the HDAB keeps the decision. This must be agreed with the HDA before it is used.



Application

Data user applies to the HDAB

Forwarded

HDAB forwards the request to SHARE

Assessment

SHARE checks it against the EHDS criteria and proposes a decision (within x weeks)

Decision

HDAB decides and is not bound by the proposal (within y weeks)

Delivery

SHARE makes the data available in its SPE

What the EHDS already allows

Art. 72, trusted health data holders: Member States may designate trusted holders that assess applications and propose a decision. The HDAB decides and is not bound by the proposal. Approved data are provided through the holder's own secure processing environment.

Open points with the HDA

- Can SHARE, as an HDIE, and acting for its members (art. 50(3)), be designated?
- Which requests count as "mainly SHARE data"?
- Reporting and audit towards the HDAB

OPERATING SCOPE

Six capabilities, built once for all members

Shared at network level rather than rebuilt by every data holder.

Data model and catalogue

Help every member implement and maintain its local OMOP; maintain the SHARE profile and mappings; generate catalogue records.

ETL and refresh technology

Reusable connectors, mapping packages, incremental ETL, monitoring and quality checks; refresh frequency set per data domain.

Federated request execution

Turn each permit into one versioned query package, distribute it, and coordinate one local release per data holder.

Free text to structured data

Optional LLM-based extraction of clinical concepts into the local OMOP; no data retention; local deployment possible.

Secure processing environment

Isolated workspaces, identity and access, audit logging, output control and teardown; access governed by the permit.

Data and project management

One operational contact per request: scope, site coordination, data quality, timelines and close-out.

OPEN AND AUDITABLE

Our operating commitments

1

Local control

Source systems and the local OMOP stay in each data holder’s environment.

2

One open standard

One versioned data-model profile, vocabulary and mapping governance, shared with all members.

3

One query, many sites

Requests are written once and run the same way at every compliant site.

4

Metadata first

Only metadata flow to the national catalogue; person-level data move only under a permit.

5

Decision versus execution

The HDAB decides on access. SHARE executes the approved workflow.

6

Secure environment by default

Approved person-level use happens in an SPE; only anonymised results leave.

7

Auditable by design

Mappings, ETL and query versions, releases and SPE activity are logged and reproducible.

8

Voluntary per project

Each member decides per project whether it takes part (statutes art. 25).

IMPLEMENTATION SEQUENCE

From standard to national scale in six steps

Each step is tested with voluntary pilot institutions before the next one scales.



Step 1 — Freeze the SHARE profile

Data-model and vocabulary versions, national terminology mappings, mandatory fields, quality thresholds

Step 2 — Local node and extractor

Build the SHARE node and common catalogue extractor; pilot identical metadata at volunteer sites

Step 3 — HDAB interface

Agree permit payload, dataset scope, site selection, status callbacks, audit trail and SPE hand-off

Step 4 — Federated query library

Operationalise the query library and the local one-click release workflow

Step 5 — SPE and end-to-end pilot

Catalogue → application → permit → federated retrieval → SPE → controlled output

Step 6 — Scale onboarding

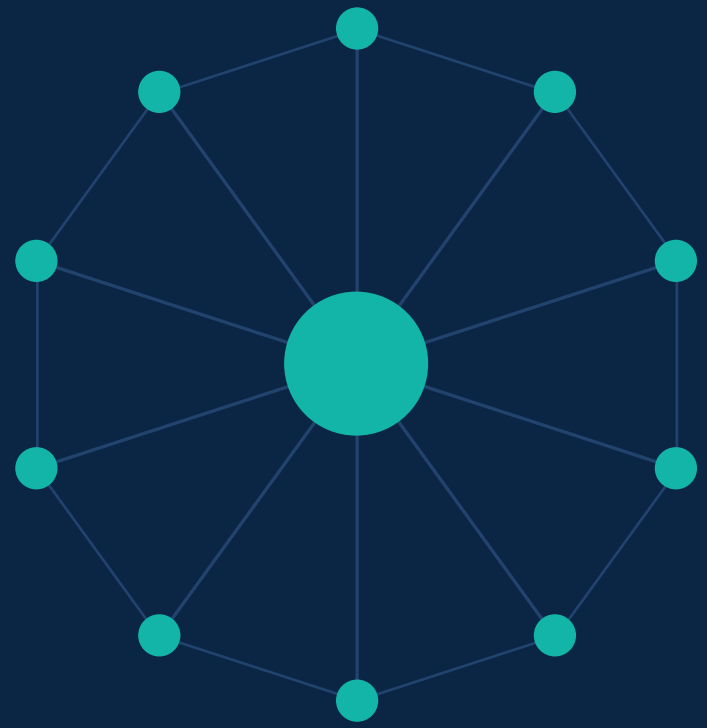
Hospitals, primary care, psychiatric centres, elderly care and other eligible members

SHARE starts operating in spring 2027, well ahead of the EHDS secondary-use deadline of 26 March 2029.

02

Governance

Owned and governed by the care providers that produce the data.



MEMBERSHIP

Open to every care provider generating data

Belgian non-profit entities that provide care directly and generate health data in doing so (statutes art. 8).

Hospitals

GP practices and multidisciplinary centres

Home care and home nursing

Nursing homes, rehabilitation, mental health

Community pharmacies

Other direct care providers

Partners

Universities, umbrella organisations, interest groups, public bodies and companies work with SHARE through contracts: framework agreements approved by the General Assembly, or project agreements.

Partners have no vote. Results and IP of a project follow participation in that project.

Annual fee at the start: €10,000 per hospital member. Other care providers: set by the board per cluster.

HOW DECISIONS ARE MADE

Members decide in the General Assembly

One member, one vote within its cluster. The two clusters are then weighted; hospitals keep a majority.

General Assembly

All members · approves statutes, budget, accounts; elects the chair and the board members

elects

Board members

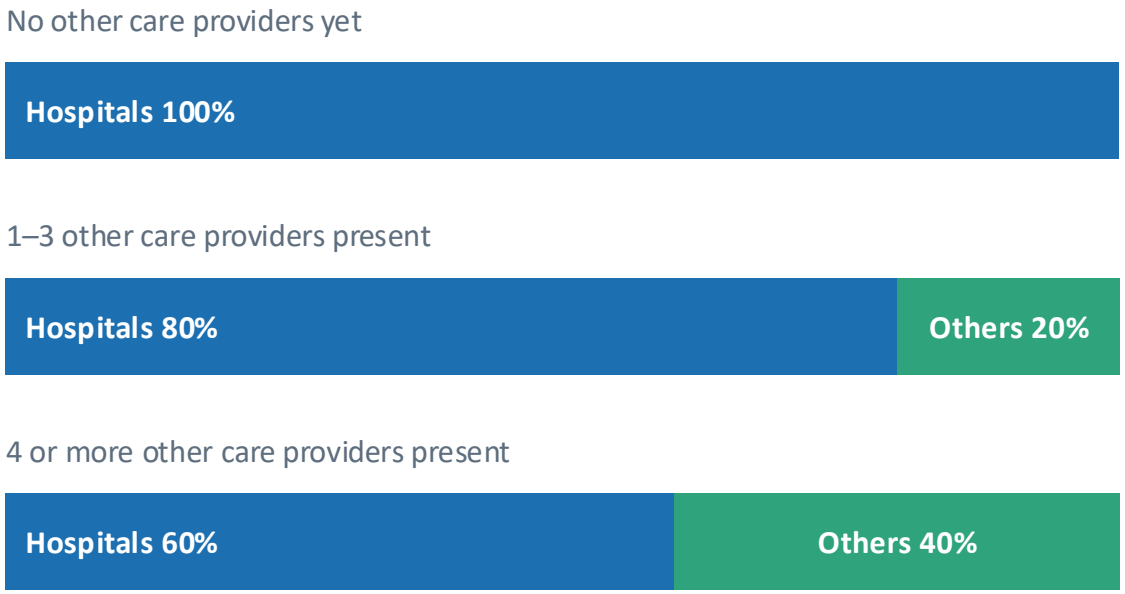
Collegial board elected from the members; meets at least three times a year

appoints

General Director

Daily management, within budgets set by the GA and the board

Weight of each cluster in the General Assembly

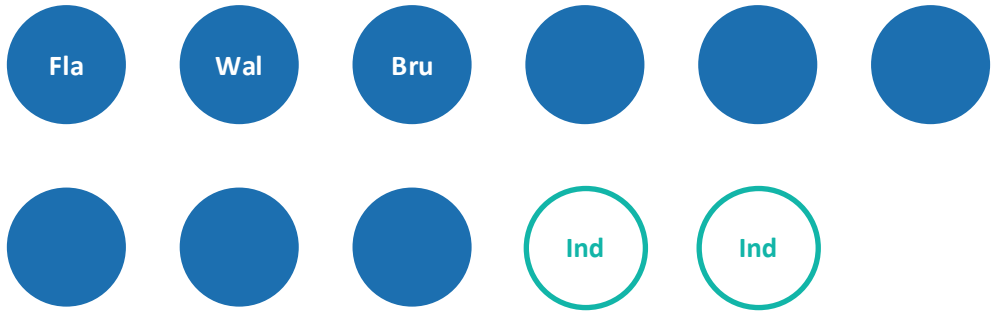


A proposal passes with more than 50% of the weighted votes. Statutory changes, exclusion and dissolution need qualified majorities.

THE BOARD

An elected board that represents every Region

Nine directors from the members, elected by the General Assembly by secret ballot. Up to three independent directors can be added.



● member directors (9) ○ independent directors (up to 2)

- Four-year terms, renewable; directors are unpaid
- Each hospital member may nominate at most one candidate
- No seat reserved for any institution or network
- Chair elected by the GA; cannot be the General Director

Every Region represented

At least one hospital director from Flanders, Wallonia and Brussels, as long as a hospital from that Region is a member.

Seats grow with other care providers

4–9 such members: 1 of the 9 seats. 10 or more: 2 seats. Nominated by that cluster.

Independent directors

Up to two, added by the General Assembly. Intended for e.g. the federal government.

WRITTEN INTO THE STATUTES

Safeguards that keep SHARE open and accountable

Secret ballot

Every vote on persons is secret (art. 16.7).

Members set the agenda

1/20 of the members can add an item to the General Assembly agenda (art. 15.2).

Members can convene

1/5 of the members can call an extraordinary General Assembly (art. 15.3).

No reserved seats

No fixed seats or vote weights for individual institutions or networks (art. 16.9, 17.3).

Separation of roles

The chair is elected by the GA and cannot be the General Director (art. 16.9).

Conflicts of interest

A conflicted board member declares it and leaves the deliberation and vote (art. 19).

Objective admission

Non-discriminatory criteria; a refused candidate can appeal to the General Assembly (art. 8.5).

Financial control

The GA approves budget and accounts; fee increases above the cap need GA approval (art. 8, 14).

AN OPEN START

Everyone can be a founder

SHARE starts small enough to operate, then opens its founding phase to every care provider in Belgium.

1

Founding

Members of FHIN, Levilo and the SPECTRE-HD project establish SHARE vzw.

2

Start-up board

A first board, at the minimum size needed to operate SHARE.

3

Open founding window

Every Belgian care provider is invited to join as founding member (“stichtend lid”) for a limited period.

4

Fully elected board

The General Assembly elects the full board; the start-up directors continue.

Joining later is not joining second: every care provider that joins during the founding window has the same status as the first founders.

WALLONIA AND INAH

Building on eight years of Walloon investment

INAH, funded by the Walloon Region, has run a hospital data network for about eight years. Two models protect that investment.

A INAH independent, same technology

INAH remains an autonomous network and uses the same technical solution as SHARE: the same standard and the same federated platform.

What it secures

- Full autonomy for INAH and the Walloon Region
- Interoperable with SHARE by design

What must be agreed

- Two governance structures towards the HDAB
- Joint management of the common standard

B One platform, INAH services

The federated platform and local data models are governed nationally by SHARE. INAH handles data requests and operates a secure processing environment.

What it secures

- One national standard and catalogue
- Walloon investment reused in a clear service role

What must be agreed

- Division of tasks and funding between SHARE and INAH

In both options: one technical standard and data stays at the source. Walloon member hospitals get at least one board seat by statute.

AN OPEN INVITATION

Build it with us

Join as a founding member

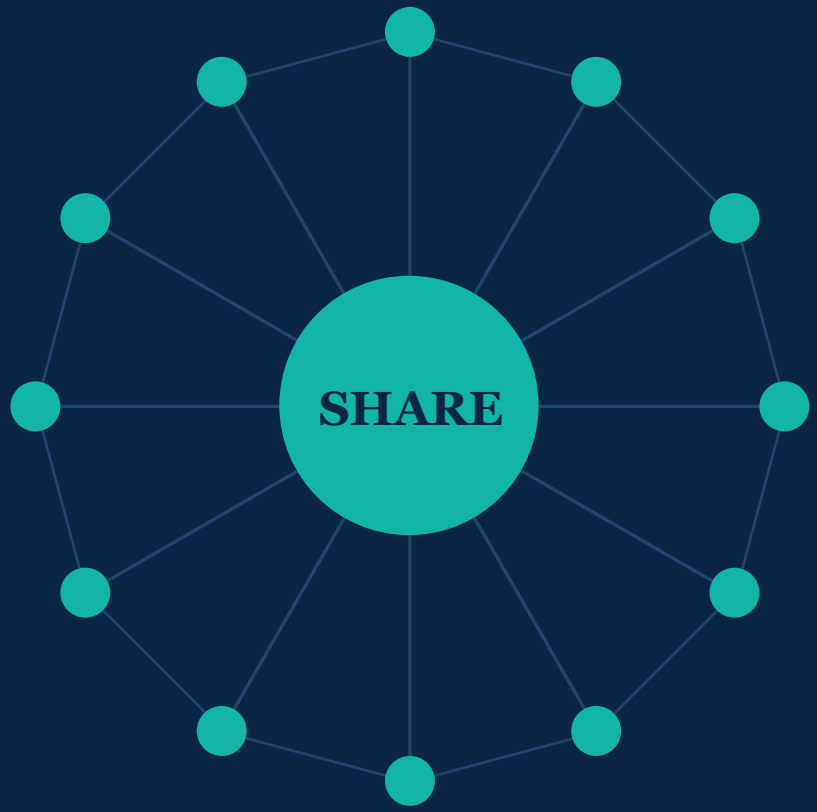
Every care provider that generates health data can join during the founding window.

Shape the SHARE standard

Contribute to the data-model profile, mappings and quality rules.

Partner with us

Universities, public bodies and companies can work with SHARE through agreements.



Questions and discussion