

Health Data Research
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ALLIANCE
Recherche sur les données de santé

A Joint Submission of the HDR Alliance on:

***Bill S-5: Connected Care for Canadians Act
Ensuring Interoperability Enables Lawful, Governed
Use of Health Data***

April 2026

Joint Submission of the Health Data Research (HDR) Alliance on Bill S-5

April 27, 2026

Standing Senate Committee on Social Affairs, Science and Technology (SOCI)

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We strongly support Bill S-5 as a necessary step to address fragmentation and vendor lock-in in Canada's health data ecosystem. The Bill's focus on interoperability and prohibition of data blocking is well aligned with improving patient safety, continuity of care, and system performance.

We note that Bill S-5 is being publicly framed not only as a technical reform, but as an enabler of patient-centred, evidence-based decision-making, research and system improvement, and AI-driven innovation in health care.

These objectives are reflected in:

- the Bill's preamble, which refers to use of health information by researchers,
- Senate discussions linking interoperability to research and AI, and
- public statements from CIHI and others emphasizing a national data foundation for innovation.

However, interoperability alone will not achieve the bill's stated goals of enabling research, innovation, and AI. The effectiveness of Bill S-5 will depend on how "data blocking," "use," and "interoperability" are interpreted in regulation and practice.

To ensure the Bill delivers on these objectives, its implementation must address not only technical exchange, but also practical barriers to lawful and authorized use of data including contractual, financial and operational barriers.

We recommend that Health Canada clarify that:

- Where a health information custodian/trustee has lawful authority and provides explicit approval, and applicable privacy law permits the activity, health information technology vendors must not impede access, extraction, exchange, or use of data, including technical, contractual, financial, or operational impediments.
- "Use" includes lawful, governance-approved purposes such as research, system evaluation, quality improvement, and AI development.
- Interoperability requires complete, usable, and standards-compliant data access, not partial or vendor-limited interfaces.
- Governed platforms (e.g., secure research and analytics environments) fall within the scope of "health information technologies."
- Vendor-controlled analytical or AI interfaces must not substitute for independent, custodian-authorized data access.



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These clarifications are consistent with the statutory language of Bill S-5, Senate debate linking the Bill to research and AI, and public positions from CIHI, Canada Health Infoway, the Canadian Medical Association, and other national health organizations. Without this clarity, there is a risk that interoperability will be achieved technically, while meaningful, lawful use of data remains constrained in practice.

We are sharing this submission with key federal, Senate, and national data system partners to support alignment as regulations are developed.

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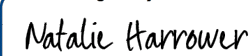
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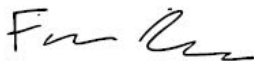
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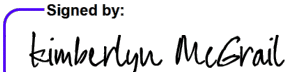


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Joint Submission to Health Canada Bill S-5, Connected Care for Canadians Act

Ensuring that Interoperability Enables Meaningful, Lawful, and Governed Use of Health Data in Canada

1. Introduction

We welcome Bill S-5, the Connected Care for Canadians Act, as an important and necessary step toward improving interoperability across Canada's health information systems. We support the bill's core objectives: reducing fragmentation, prohibiting data blocking, improving continuity of care, and enabling secure access to health information in a way that improves patient safety and system performance. Health Canada has framed the bill as foundational to a more connected health care system, and Senator Joan Kingston has framed it as a response to a fragmented environment in which records are inaccessible, standards are inconsistent, and both patients and clinicians are harmed by missing information.

We agree that the bill is properly directed at vendors and technical interoperability. At the same time, we submit that interoperability alone will not achieve the broader objectives already associated with the bill in public statements, including research, innovation, AI readiness, and evidence-based decision-making. The bill's own preamble states that a connected and secure system that allows health information to be used efficiently "...will help governments, health care administrators and researchers make evidence-based decisions and fuel innovation." Senator Kingston likewise linked the bill directly to research and AI-driven innovation, and Health Canada's news release includes supportive statements from CIHI and Canada Health Infoway that connect the bill to research, innovation, AI at scale, and trusted data sharing.

This submission focuses on the implementation question that will determine whether Bill S-5 delivers on those broader objectives in practice: how "data blocking," "interoperability," and "use" should be interpreted where a health information custodian has lawful authority and gives explicit approval for data to flow to a governed, privacy-protecting platform for research, quality improvement, system evaluation, or AI development.

2. The Opportunity and the Implementation Gap

Bill S-5 addresses an important but specific problem. It seeks to remove technical and vendor-related barriers that prevent electronic health information from being accessed, used, and exchanged. It does not replace provincial or territorial privacy law, and Senator Kingston stated in Senate debate that the bill does not impact existing privacy legislation and does not compel data sharing. Health Canada has made the same point publicly, stating that the Act "enables, not compels" secure access and sharing while respecting existing privacy legislation.

That design is appropriate. However, it creates an implementation gap. In Canada today, practical barriers to access often do not arise only from privacy law. They arise from a combination of vendor architecture, contractual limits, approval ambiguity, partial interfaces, unreadable exports, excessive fees, long delays, and the inability to obtain data in a form that



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is complete and usable for the authorized purpose. The Canadian Medical Association (CMA) has described this problem in concrete terms, noting that clinics and institutions can face denials, long waits, unreadable data dumps, or excessive fees when they seek to add third-party software, switch vendors, migrate, or extract patient records.

In our view, Bill S-5 will fall short of its stated purpose unless regulations make clear that "data blocking" includes not only refusal to exchange data with another clinical system, but also technical, contractual, financial, and operational practices that frustrate lawful, governance-approved use of data for research and data analytics to inform health system policy and practice and enable learning health systems. This is especially important where the use in question has been expressly approved by the relevant health information custodian and is otherwise lawful under the applicable provincial privacy regime. The statute's definition of "data blocking" is already broad enough to support this approach because it covers practices that prevent, discourage or interfere with access to, or the use or exchange of, electronic health information. The statutory purpose is similarly broad because section 3 speaks of enabling "access to and use and exchange" of electronic health information, not exchange alone.

3. Why the Regulatory Interpretation Matters

The legal and policy centre of gravity in Bill S-5 is not the face of the statute alone. It is the regulation-making power. Section 8 allows regulations to specify standards and requirements for interoperability, define practices or acts that constitute data blocking, authorize compliance verification, create complaints processes, and establish administrative monetary penalties. Senator Kingston told the Senate that the "real work" on regulations is expected to begin quickly and that stakeholders are looking forward to working with the government on that process. This means Health Canada now has a meaningful opportunity to clarify how the bill will work in real settings, including in the context of authorized secondary uses.

That regulatory clarification is needed because there is a real risk of narrow interpretation. Section 5(2)(a) says interoperable technology must allow the user to easily, completely and securely access and use all electronic health information and exchange all electronic health information with other health information technologies, unless applicable privacy law prohibits that access, use and exchange. A narrow reading could treat the phrase "with other health information technologies" as limiting the bill to clinical system-to-system exchange. Vendors may therefore argue that the bill applies only to care-delivery interoperability and does not reach governed research platforms, analytic environments, or learning health system infrastructures.

We submit that this narrow reading should be rejected. First, the definition of "health information technology" is itself broad. It includes hardware, software, integrated technologies, intellectual property and upgrades designed for creating, maintaining, accessing, using or exchanging electronic health information, or that support such activities. Second, the bill separately defines "data blocking" in relation to access, use, or exchange, not only exchange. Third, the preamble expressly contemplates efficient use of health information by researchers.



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Fourth, Senator Kingston explicitly linked the bill to the use of standardized, shareable anonymized data for research and AI-driven innovation, and said researchers could use such data to improve health and help prevent public health emergencies.

Accordingly, the better interpretation is that where a lawful, governance-approved use exists, the vendor's role is to enable rather than obstruct. The relevant limiting condition is not whether the vendor prefers the transfer or whether the endpoint is inside the vendor's own ecosystem. The relevant limiting condition is whether applicable privacy law prohibits the access, use, or exchange. If privacy law does not prohibit it, and the custodian has authorized it, then the vendor should not be permitted to frustrate that use through technical, contractual, financial, or operational barriers. Section 5(2)(a), read together with section 6 and the preamble, supports precisely that interpretation.

A further consideration should be whether there is 'public good' in the use of the data. For example, [evaluation criteria for the use of health data in the UK](#) specifies public good including: (i) provide a better understanding of the health and care needs of populations; (ii) lead to the improvement of health and care outcomes or experiences; (iii) help manage the response to communicable diseases and other risks to public health; and (iv) advance the understanding of national trends in health and social care needs.

4. Clarifying "Data Blocking" Across Three Dimensions

We recommend that Health Canada clarify, in regulation or guidance, that data blocking may arise across at least three dimensions.

First, technical blocking. This includes failure to provide interfaces, refusal to support common standards, unreadable exports, degraded data formats, excessive delays, and architecture-based claims that key elements of the record are not available for extraction. These are the most obvious forms of data blocking and are already reflected in public discussion of the bill. CMA's public explanation is especially useful here because it translates the concept into practical scenarios familiar to providers and institutions.

Second, contractual, financial and operational blocking. This includes agreements or approval structures that make lawful use practically impossible, especially where responsibility is fragmented or ambiguous. For example, vendor costs for data extraction and movement are often prohibitive for publicly funded organizations. Senator Kingston's speech repeatedly returned to the reality that information is "stuck in separate systems" due not only to standards gaps but also to business interests. In practice, it is common for organizations to be unable to determine who can authorize a flow, or to face such fragmented approval pathways that access is effectively impossible even when no privacy law forbids it.

Third, purpose-based blocking. This is the most important issue for governed research and innovation infrastructures. Some vendors may accept that data should move between clinical systems but argue that the bill does not reach authorized uses for research, system evaluation, or AI development. We submit that this interpretation is inconsistent with the bill's purpose and public rationale. CIHI has described the bill as helping to build a national data foundation that



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enables research, innovation and AI at scale. The Canadian Cancer Society has welcomed the bill as creating opportunities for innovation in research, clinical trials and diagnostics by cutting red tape and streamlining data collection. Senator Kingston explicitly referred to researchers using standardized data to improve health and to innovators building technology for a different future health system. These statements show broad support for a reading that lawful, governed use is part of the bill's practical objective, even if the bill is vendor-facing and not itself a complete data-governance statute.

5. Custodianship Clarity as a Precondition to Interoperability

A recurring practical challenge in Canadian health data is ambiguity over who has authority to approve access or downstream use. In some settings the relevant party may be a hospital, clinic, home, or physician group. In others it may be a regional authority, corporate operator, or another entity acting as custodian or delegated authority under provincial law. Even where the legal answer exists in principle, the operational path is often unclear. This produces a form of de facto data blocking because requesters cannot determine where approval authority sits or how to exercise it efficiently.

We therefore recommend that implementation guidance explicitly address custodianship clarity and delegated approval pathways. At minimum, vendors should not be allowed to rely on governance ambiguity as a reason to delay or frustrate a transfer where the relevant custodian or delegated authority has in fact provided explicit, lawful approval. Put simply, governance ambiguity should not become a functional defense to data blocking. This recommendation is consistent with the bill's goal of enabling easy, complete and secure access and use, and with the broad stakeholder consensus recognized in the preamble.

6. Interoperability Must Mean Complete and Usable Access

The bill should not be implemented in a way that lets interoperability be satisfied by token or partial access. The statute requires access and use that are "easy, complete and secure." Those words matter. In practice, vendors often argue that full application programming interface (API) access is not available, that only some modules or tables are exposed, or that complete extraction is impossible because the architecture was not designed to support it. If accepted at face value, those assertions would defeat the bill's purpose by allowing vendor design choices to define the outer boundary of interoperability.

We therefore recommend that regulations make clear that interoperability is not satisfied by partial, degraded, or vendor-restricted access mechanisms where more complete access is required for the authorized purpose. If a health information custodian lawfully authorizes disclosure or transfer of a complete dataset to a governed platform, the vendor should be required to provide the data in a format that is complete, standards-compliant, and usable for that purpose. The fact that an existing API does not expose all of the record should not itself be treated as a valid reason to deny or narrow access. Otherwise, technical limitations chosen by the vendor become a self-justifying form of data blocking.



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This point is aligned with the wider public discussion of the bill. CMA has warned against unreadable data dumps and extraction barriers. CIHI has emphasized the need for clear, connected and privacy-protecting rules for data use. Canada Health Infoway has emphasized trusted data sharing and modern digital standards. The Society of Rural Physicians of Canada and the College of Family Physicians of Canada have both framed common standards and interoperability as necessary for high-quality care across settings. A regulation that permits only partial or unusable access would not meet the standard implied by these aligned statements.

7. "Health Information Technologies" Should Include Governed Data Environments

To avoid uncertainty, Health Canada should clarify that the phrase "other health information technologies" in section 5(2)(a) includes secure, governed data environments and platforms that are authorized by health information custodians and operate within applicable privacy law. This would include research platforms, analytics infrastructures, and learning health system environments, provided they are subject to appropriate governance, confidentiality controls, and legal authority.

This recommendation does not ask Health Canada to create a new open-access right. It does not seek to override provincial law. It simply asks Health Canada to confirm that vendor obligations are not exhausted by exchange inside the clinical vendor ecosystem alone. That interpretation is supported by the broad statutory definition of health information technology, the express inclusion of de-identified information in the definition of electronic health information, the preamble's reference to researchers, and repeated remarks in Senate debate, including Senator Kingston's reliance on research and AI as part of the bill's rationale.

This clarification would also be consistent with the policy direction expressed by the Canadian Cancer Society, which linked the bill to research, clinical trials and diagnostics, and to the pan-Canadian Cancer Data Strategy developed with the Canadian Partnership Against Cancer. It would be consistent with CIHI's statement that the bill can help build a national data foundation for research, innovation and AI at scale. And it would be consistent with Health Canada's own statement that the bill is part of the foundation needed for AI innovations that improve care, efficiency and economic opportunity.

8. Preventing a New Form of Data Blocking: Vendor-Controlled AI and Analytical Layers

A further risk deserves explicit attention. As interoperability pressures grow, some vendors may respond not by enabling meaningful downstream access but by offering proprietary AI or query layers in front of the data and treating those interfaces as substitutes for access. Such tools may have value, but they should not be allowed to replace a custodian's ability to authorize a lawful transfer of data to an independently governed environment.

If the practical result is that a vendor says, in effect, "you may ask our AI system questions, but you may not obtain the underlying dataset for your own governed and approved use," then



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interoperability has not solved the problem. It has simply re-intermediated the data through a vendor-controlled abstraction layer. This would undermine transparency, reproducibility, independent validation, and public-interest research.

We therefore recommend that Health Canada clarify that the availability of vendor-controlled analytical tools does not satisfy interoperability obligations where the custodian has lawfully authorized access, extraction, exchange, or disclosure of the relevant data to another governed environment. Put differently, vendor-mediated outputs should not be permitted to displace independent, custodian-authorized use. Senator Osler's intervention in the Senate usefully highlights the concern on the other side of this same issue: once silos are broken down, there is anxiety about unauthorized secondary use by vendors for AI training or commercial purposes. A balanced implementation of the bill should therefore do two things at once: prevent vendors from blocking lawful, custodian-approved data flows, and avoid creating any implication that the bill gives vendors broader entitlements to use customer data for their own purposes.

9. Broad Public Support for a Strong but Bounded Interpretation

Our recommendations are not an attempt to change the bill's nature. They are an attempt to implement it consistently with how major public voices have already framed it.

Senator Kingston has repeatedly described the bill as addressing both patient safety and the need for standardized, shareable data for research and AI-driven innovation, and she explicitly described data blocking as preventing authorized users from accessing data even when privacy legislation allows it. That formulation strongly supports a regulatory approach focused on lawful authority rather than vendor preference.

Health Canada has emphasized that the bill is about enabling secure access and information sharing, that it will help establish a foundation for AI innovations in the health sector, and that regulations are being developed collaboratively while respecting existing privacy legislation.

CIHI has publicly endorsed the bill as helping to build a national data foundation that enables research, innovation and AI at scale. Canada Health Infoway has emphasized trusted data sharing and modern digital standards. The Canadian Cancer Society has tied the bill to better governance, standardized and linked data, and new opportunities for research, clinical trials and diagnostics, while situating it within the pan-Canadian Cancer Data Strategy developed with the Canadian Partnership Against Cancer. CMA has translated the problem of data blocking into concrete operational barriers, including denials, long waits, unreadable exports and excessive fees. Together, these voices show broad support for a model in which the bill remains vendor-focused and privacy-bounded, but is implemented strongly enough to support public-interest use cases that are lawful and custodian-authorized.

10. Recommendations

We respectfully recommend that Health Canada ensure, through regulation and implementation guidance, that:



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1. "Data blocking" is interpreted to include technical, contractual, administrative, and purpose-based practices that prevent, discourage, or interfere with lawful, governance-approved access to, use of, or exchange of electronic health information. This recommendation is grounded directly in the statutory definition and purpose.
2. "Use" under the Act is understood to include lawful, governance-approved secondary uses, including research, system evaluation, quality improvement, and AI development, where such uses are permitted under applicable provincial or territorial law and explicitly approved by the relevant health information custodian. This is supported by the preamble, Senate debate, CIHI's public endorsement, and statements from the cancer sector.
3. "Other health information technologies" is interpreted to include secure, governed data environments and platforms authorized by health information custodians, not only point-of-care or vendor-operated clinical systems. The bill's broad definition of health information technology supports this clarification.
4. Interoperability requires complete and usable access to the data necessary for the authorized purpose. Partial, degraded, or vendor-restricted interfaces should not be treated as compliance where they prevent meaningful use. This is consistent with the statute's repeated emphasis on ease, completeness, and security.
5. Vendors may not rely on their own architectural choices, incomplete APIs, proprietary formats, excessive fees, unreadable exports, or long delays to frustrate a lawful, custodian-authorized flow of data to a governed platform. Those practices should be identified expressly, or by clear guidance, as forms of data blocking. CMA's practical examples strongly support this recommendation.
6. Governance ambiguity should not operate as a functional defense to data blocking. Where the relevant health information custodian or delegated authority has given explicit, lawful approval, the vendor should be required to enable the authorized transfer. This is necessary to make interoperability real in practice.
7. The existence of vendor-controlled analytical or AI interfaces should not be treated as a substitute for independent, custodian-authorized access to data where such access is lawful and required for the authorized purpose. This is necessary to prevent a new form of vendor-mediated data blocking while respecting Senator Osler's concern about unauthorized secondary use by vendors.

A concise statutory interpretation supporting this position, grounded in the text of Bill S-5, is provided in Appendix A.

11. Summary

Bill S-5 is a necessary and constructive step. It opens the door to a more connected, secure and person-centered health system. But the door will only open part way if interoperability is interpreted narrowly as clinical system-to-system exchange while governed public-interest use remains vulnerable to vendor-controlled barriers.



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The bill can and should be implemented in a way that preserves existing privacy law, respects custodianship, prevents unauthorized vendor secondary use, and still ensures that where a health information custodian has lawful authority and gives explicit approval, a vendor cannot obstruct access, extraction, exchange, or disclosure of that data to a trusted and governed platform. That is not an expansion beyond the bill's purpose. It is the practical condition for delivering on the bill's stated goals of patient safety, evidence-based decision-making, research, innovation, and AI readiness.



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Appendix A

Legal Interpretation Memorandum

Bill S-5 and Custodian-Authorized Data Access to Governed Platforms

Purpose

This provides a concise statutory interpretation in support of the submission above. It is not legal advice. Its purpose is to identify the strongest available reading of Bill S-5 for the scenario in which a health information custodian lawfully authorizes access, extraction, exchange, or disclosure of data to a secure, governed platform under applicable provincial law.

A. The bill is not only about exchange

The text of the bill does not limit itself to exchange between clinical systems. The definition of "data blocking" includes practices that prevent, discourage or interfere with "access to or the use or exchange of" electronic health information. Section 3 states that the purpose of the Act is to enable "access to and use and exchange" of electronic health information. The inclusion of "use" in both provisions is significant. It indicates that the Act should not be read as limited to mere transport of data from one clinical endpoint to another.

B. The bill is not limited to identified clinical records

"Electronic health information" is defined to include electronic personal health information whether or not it has been de-identified. This is important because much of the public conversation around research and AI concerns de-identified or anonymized data. The bill's express inclusion of de-identified information supports an interpretation under which governed research and innovation uses fall within the statute's practical field, even though the Act remains structured as a vendor-interoperability law rather than a complete secondary-use framework.

C. "Health information technology" is defined broadly

The statutory definition of "health information technology" includes hardware, software, integrated technologies, intellectual property and upgrades that are designed for creating, maintaining, accessing, using or exchanging electronic health information, or that support such activities. This breadth matters. It weakens any argument that the phrase "other health information technologies" in section 5(2)(a) must be confined to point-of-care EHRs or vendor-operated clinical applications. On an ordinary reading, a secure governed data platform can fall within this definition if it is designed to access, use, or support the use of electronic health information.

D. The limiting principle is privacy law, not vendor preference

Section 5(2)(a) provides that technology is interoperable if it allows the user to easily, completely and securely access and use all electronic health information and exchange all electronic health information with other health information technologies, unless applicable federal, provincial or territorial law on personal health information prohibits that access, use



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and exchange. The structure of the clause matters. The textual limit is legal prohibition under privacy law, not vendor preference, product design, API scope, business model, or contract architecture. A strong interpretive argument therefore follows: where applicable privacy law does not prohibit the access, use, or exchange, and the relevant custodian has authorized it, the vendor should be required to enable it.

E. The preamble supports a broader reading tied to research and innovation

The preamble states that a connected, secure health system that allows information to be used efficiently will help governments, health care administrators and researchers make evidence-based decisions and fuel innovation. While a preamble does not override operative provisions, it is a recognized aid to interpretation where statutory meaning is contested. Here it supports a reading of the Act that extends beyond bedside viewing and includes public-interest analytic uses that remain lawful and governed.

F. Senate debate supports this interpretation

In Senate debate, Senator Kingston described the bill as addressing not only patient safety and continuity of care, but also the lack of standards that limits the potential for de-identified data to be used in research and AI-driven innovation. She also described data blocking as a practice that prevents authorized users from accessing health data even when privacy legislation allows it. While legislative debate does not control statutory meaning, it is useful contextual evidence of the mischief the bill seeks to address and the practical understanding of its sponsor.

G. The strongest counterargument

The strongest counterargument is that section 5(2)(a) refers to exchange with "other health information technologies" and that public statements from Health Canada and Senator Kingston often describe the bill as enabling secure access for patients and information sharing between health care providers within the circle of care. A narrow regulator or vendor may therefore argue that the Act is not intended to reach research platforms or analytic environments. Health Canada has also publicly emphasized that the bill is not creating a digital platform or database and does not compel data sharing.

H. Why the broader interpretation is still preferable

That counterargument should not prevail for three reasons.

First, the statute separately protects "use," not only exchange. Second, the definition of health information technology is broad enough to include governed platforms. Third, the preamble and sponsor's speech both expressly connect the bill to research and innovation. The better reading is therefore a bounded one: the Act should not be read as creating a general right of access for any third party, but it should be read as preventing vendors from blocking access, use, or exchange where the use is lawful under applicable privacy law and explicitly authorized by the relevant custodian.



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I. Practical implication for regulation

The regulation-making power in section 8 is broad enough to resolve this ambiguity constructively. Health Canada can specify practices that constitute data blocking, articulate what counts as complete and usable access, and clarify that governed, custodian-authorized platforms are within the scope of interoperable exchange and use. It can do so while preserving the bill's architecture, preserving provincial privacy law, and avoiding any implication that vendors gain broader rights to exploit customer data for their own purposes.

J. Bottom line

On the strongest available reading of Bill S-5, where a health information custodian has lawful authority under applicable provincial law and gives explicit approval for access, extraction, exchange, or disclosure of its data to a secure, governed platform, a health information technology vendor should not be permitted to impede that activity through delay, excessive fees, non-standard outputs, unreadable formats, refusal to support interfaces, or other technical, contractual, financial or operational barriers. That reading is consistent with the statute's text, the preamble, Senate debate, and the wider public rationale advanced by Health Canada, Canadian Institute for Health Information, Canada Health Infoway, Canadian Medical Association, and the Canadian Cancer Society.



Joint Submission of the Health Data Research (HDR) Alliance on Bill S-5

About the Health Data Research Alliance

The [Health Data Research \(HDR\) Alliance](#) is an initiative of [Health Data Research Network Canada \(HDRN Canada\)](#). We work collaboratively on projects that advance transformative data use to drive improvements in health and health equity. The HDR Alliance generates collective benefit to members by sharing specialized knowledge and best practices, cooperating on shared strategic interests, and building a base of support to strengthen world-leading health data use policies and practices that foster Canada's health data ecosystem. Working together, we help shape the future of health data by advocating for the long-term sustainability of a pan-Canadian health data ecosystem and influencing strategic directions across the country. We advance opportunities that make health data easier to find, access and use for multi-regional research. We engage with researchers and policymakers to promote world-leading policies and practices for responsible data use. We promote and enable adherence to established principles of data stewardship. Above all, we act as a catalyst for partnerships and joint initiatives that strengthen Canada's health data ecosystem.

The HDR Alliance expands opportunities for pan-Canadian research that informs health-related policy and practice.

- We collaborate to share data responsibly between members, expanding the possibilities for larger, more impactful studies across Canada.
- We support thousands of researchers using health and health-related data to do multi-regional studies. We work together to generate real-world evidence to support decision-makers with timely, actionable insights to inform health system policy and practice.

The HDR Alliance leads in methodological innovation and in preparing the next generation of researchers.

- We develop new methods to enable analysis across multiple data platforms without moving data to accelerate health research in Canada, using advanced analytic tools.
- We offer information-sharing and training programs for researchers, students and others. We provide tools to support learning and discovery, including synthetic datasets and free curated open datasets.

The HDR Alliance acts as a national “brain trust” on health and health-related data stewardship.

- We advise and guide federal and provincial governments on modernizing health data laws, policies and practices.
- We lead public engagement initiatives and develop resources on public trust and data literacy, helping the public understand how and why data are used.
- We uphold Open Science, producing guidelines on transparency and reproducibility, and openly publishing protocols, research tools and reports.



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Member Signatories:

The HDR Alliance includes many members. Below is a list of the members who are signatories to this submission.

[Advanced Research Collaboration for Health Integration, Medical Exploration, and Data Synthesis \(ARCHIMEDES\)](#)

[Canada Supporting Partnerships to Advance caRe and Knowledge in Long-Term Care \(CanSPARK LTC\)](#)

[Canadian Centre for Recovery Excellence \(CoRE\)](#)

[Canadian Health Information Management Association \(CHIMA\)](#)

[Canadian Longitudinal Study on Aging \(CLSA\)](#)

[Canadian Network for Observational Drug Effect Studies \(CNODES\)](#)

[Canadian Neuromuscular Disease Registry \(CNDR\)](#)

[Canadian Partnership For Tomorrow's Health \(CanPath\)](#)

[Canadian Research Data Centre Network \(CRDCN\)](#)

[GEMINI / VITAL](#)

[Health Data Research Network Canada \(HDRN Canada\)](#)

