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**Disclaimer**

This project is led by The Health Policy Partnership (HPP) with guidance from a multidisciplinary group of experts. HPP has full editorial control of all outputs and is guided by experts with the aim of reflecting a consensus position. The project is supported with funding by Novartis.

The  
**Health Policy**  
Partnership






# THE FUTURE OF ADVANCED CANCER THERAPIES IN IRELAND

Endorsed by:





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## ABOUT THIS WHITE PAPER

This white paper draws on insights from national experts in nuclear medicine, oncology, radiology, haematology, radiopharmacy, medical physics, regulation, patient advocacy and policy, generated through a roundtable convened in March 2026 and supported by desk research. The [Health System Readiness Assessment Framework](#) developed by The Health Policy Partnership (HPP) guided the research and discussions, enabling a system-wide assessment of Ireland's readiness across five domains to identify capacity gaps and inform long-term planning. Together, these inputs informed an assessment of current system performance and the development of evidence-based recommendations to improve readiness for advanced cancer therapies and support equitable access.

We thank all participants for their expertise and contributions, and Irish Government Minister of State Frank Feighan for delivering the opening address at the roundtable.

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# Foreword

Ireland is at a pivotal moment in cancer care. Advances such as CAR T-cell therapy and radioligand therapy (RLT) are transforming outcomes internationally, offering hope to people living with cancer who have few remaining options. Yet in Ireland, access to these therapies remains limited, uneven and too often delayed – at a time when speed and certainty matter most.

We come together as healthcare professionals, scientists, policymakers, patient advocacy groups and people with lived experience of cancer, united by what we see every day: the life-changing potential of advanced therapies, and the human cost when people cannot access them. While progress has been made, structural barriers continue to prevent equitable, timely access, leaving outcomes dependent on location, system capacity and pathway complexity rather than patient need.

This white paper examines the delivery of and access to advanced cancer therapies in Ireland, focusing particularly on RLT. It does so through the lens of five interconnected domains: governance; regulation and reimbursement; identified patient need; service provision; and health information. These domains highlight the foundations required for a coordinated national approach, including strong leadership, clearer pathways, investment in workforce and infrastructure, and better use of data to inform planning and delivery.

From this assessment, we have developed clear, actionable recommendations to support policymakers and health system leaders in building future-ready cancer care that ensures every eligible person, wherever they live, can access advanced cancer therapies in a timely, equitable and sustainable way.

## THE AUTHORS

### Ireland

Every eligible person, wherever they live, should have access to advanced cancer therapies in a timely, equitable and sustainable way.



# Cancer care in Ireland: a system under pressure

## Where are we now?

**Cancer is placing an increasing burden on people and health systems in Ireland, with the rising number of cancer cases and deaths demanding urgent and sustained action.**

Cancer is one of Ireland’s leading causes of death, accounting for nearly 9,800 deaths annually, or 30% of all deaths.<sup>1</sup> Cancer case numbers in Ireland are steadily increasing due to population growth and ageing, with rates potentially doubling by 2045.<sup>2,3</sup> While Ireland’s *National Cancer Strategy 2017–2026* set ambitious goals to improve early detection, reduce inequalities and enhance survival,<sup>4</sup> these objectives are at risk as the strategy concludes without sustained investment in workforce, infrastructure and services.<sup>5</sup>

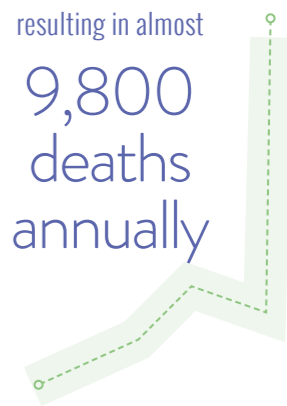
**People with cancer in Ireland face delays and inconsistent access to innovative cancer medicines, at a point when more timely treatment could mean the difference between curative care and care that only manages symptoms.**

Despite major recent advances in oncology, access to advanced therapies remains inconsistent, particularly for people relying on the public health system.<sup>6,7</sup>

In Ireland, reimbursement of innovative cancer medicines generally requires a full health technology assessment (HTA), which can take up to 971 days from submission to reimbursement (*Box 1*).<sup>8</sup> This time frame far exceeds European Union (EU) averages.<sup>9</sup>

The incidence of cancer is growing

resulting in almost  
9,800  
deaths  
annually



### BOX 1. The reimbursement process in Ireland

Once a medicine is authorised by the European Medicines Agency (EMA), the Irish Health Service Executive (HSE) must decide whether to reimburse it. The National Centre for Pharmacoeconomics (NCPE) assesses a medicine’s clinical benefit and cost-effectiveness through a rapid review assessment and, if required, a full HTA.<sup>10</sup> The pharmaceutical company may then be required to negotiate pricing with the HSE if the NCPE finds that the current price does not provide value for money.<sup>10</sup>

**Delays and constraints in Ireland’s reimbursement system leave many people unable to access the cancer treatments that their healthcare professionals believe would be most effective.** These ongoing shortcomings mean that around one in four people with cancer cannot be prescribed the medicines their clinicians believe they need. Instead, they may be treated with older or less effective options, even when newer therapies have already been approved by the EMA.<sup>7 11 12</sup>

### What are the current bottlenecks in access to advanced therapies?

**Advanced cancer therapies are expanding rapidly worldwide, and their complexity and upfront resource demands require health systems to prepare for significant growth.** A surge in global investment is reshaping the advanced cancer therapies landscape, including radiopharmaceuticals such as radioligand therapy. These therapies are complex and depend on specialist infrastructure, regulatory pathways and a skilled workforce.<sup>13</sup> Today, more than 360 clinical trials are exploring these treatments in multiple cancers, and by 2035 the pool of people who could benefit from radioligand therapies (RLTs) specifically (Box 2) is expected to be 10 to 15 times larger than it is now.<sup>14-16</sup>

There are more than **360** ongoing RLT clinical trials around the world

#### BOX 2. Radioligand therapy

Radioligand therapy is not a drug in the traditional sense but a form of nuclear medicine therapy, similar in principle to radiotherapy. Unlike chemical or biological treatments (such as chemotherapy or immunotherapy), it works by delivering a targeted dose of radiation directly to cancer cells when injected into the body.<sup>13</sup> Because the radiation acts over very short distances and is highly targeted, RLT is generally well tolerated, with limited side effects, low toxicity and faster responses than chemotherapy.<sup>17-22</sup>

**Ireland is falling further behind its European peers in translating this progress into patient access, and the gap is widening.**

Only 25% of new oncology medicines licensed since 2020 are available in the public health system in Ireland, one of the lowest rates in Western Europe (Table 1).<sup>6</sup> The average time frame from EMA authorisation to people in Ireland being treated with a new therapy now approaches two years, up from 477 days in 2020.<sup>6</sup> The absence of early access pathways, along with diagnostic and workforce constraints, further restricts timely access.<sup>23-25</sup> However, Ireland has seen some success with highly specialist therapy for blood cancers, CAR T-cell therapy, which could be emulated for RLT (Box 3).

Only **25%** of new oncology medicines are available in the public health system in Ireland, one of the lowest rates in Western Europe.<sup>6</sup>

**There is a disconnect between the growing clinical importance of RLT and wider recognition of its real-world value, resulting in restricted access for people with cancer.** In 2023, an RLT service for neuroendocrine tumours (NET) was established at St. Vincent’s University Hospital in Dublin, (supported by the National Cancer Control Programme, NCCP).<sup>26</sup> The following year, the Health Information and Quality Authority (HIQA) reviewed the quality and safety of RLT for prostate cancer and provided a generic justification for its use.<sup>27</sup> However, RLT is not currently reimbursed for people with prostate cancer.<sup>28</sup>

Table 1. Summary features of RLT system preparedness for Ireland compared with EU peers<sup>29</sup>

Dimension	Ireland	EU RLT leaders (Belgium, France, Germany, Italy, the Netherlands)
Patient access	Limited and selective; small number of treatment centres	Routine access for eligible patients across multiple centres
Nuclear medicine capacity	Constrained capacity and throughput	Extensive infrastructure and treatment slots
Radiopharmaceutical supply	Reliant on international supply chains	Domestic or highly secured supply chains
Specialist workforce	Shortages in radiology, nuclear medicine, radiopharmacy and medical physics	Larger, established multidisciplinary RLT workforce
Reimbursement pathways	Delayed and restrictive	Clear, established reimbursement mechanisms
Readiness for scale-up	Low–moderate	High, with national planning already underway

Best-practice case studies from many of these EU countries are included throughout the report.

#### BOX 3. Paving the way: the CAR T-cell therapy success story in Ireland

Establishing a national CAR T-cell therapy service in Ireland marks a major advance in improving access to highly specialist cancer care. In 2021, St James’s Hospital in Dublin was designated as Ireland’s first adult CAR T-cell centre – ending the need for people to travel abroad for this potentially life-saving therapy.<sup>30</sup> Since implementation, Ireland has developed a nationally coordinated, multidisciplinary CAR T-cell service with defined clinical pathways and quality standards, positioning the health system to deliver cutting-edge immunotherapies safely and sustainably to people with relapsed or refractory blood cancers.<sup>31</sup>



# Why health system readiness cannot wait

**The long-term cost of inaction is likely to exceed the investment required to build a system that can deliver these therapies efficiently and equitably.**

Advanced cancer therapies are no longer experimental – they are becoming standard of care. Without proactive planning, Ireland risks entrenching the very inequities it seeks to address:

- ↳ delayed or inequitable patient access
- ↳ growing reliance on costly overseas treatment
- ↳ missed opportunities for research and innovation.

Ensuring cancer policy carefully considers the level of readiness for the Irish health system to further integrate advanced cancer therapies will enable Ireland to move from reactive adoption towards a more anticipatory, sustainable model (see *Appendix*).

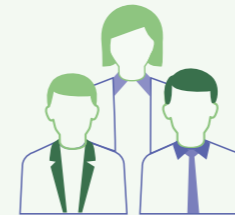
# Opportunities to improve access to advanced cancer therapies in Ireland

The challenges and opportunities highlighted in this report were surfaced through discussions at the round table. They fall under the following domains:



## Strengthening governance

### WHY IS THIS IMPORTANT?



Effective governance provides the structures needed to manage risk, coordinate multidisciplinary care, ensure equitable access, oversee outcomes and steward resources. It translates scientific innovation in advanced therapies into reliable, real-world patient care.

### WHAT IS THE CURRENT CONTEXT?

**Ireland’s ability to plan for and deliver advanced cancer therapies is being held back by delayed strategic renewal, unclear governance and fragmented decision-making.** With the 2017–2026 national cancer strategy nearing its end and no plans for its successor underway, there is no clear national direction for integrating RLT or other advanced therapies and fully integrating CAR T-cell therapy. Their absence from current strategic documents creates uncertainty around service development, workforce planning and capital investment.

**These strategic gaps are compounded by a lack of clear accountability, ownership and policy-level understanding of RLT across cancer governance and decision-making structures.** Decision-making bodies involved in funding, HTA and service commissioning are viewed as slow to respond to clinical and patient needs, while reduced leadership capacity limits proactive planning and slows adaptation to innovation.

**Reforms that have shifted cancer funding and decision-making from national to regional structures have the potential to weaken coordination, accountability and strategic planning for these highly specialist therapies.** The movement of cancer budgets from the NCCP to regional health areas will likely reduce visibility of cancer spending and make it harder to plan nationally coherent services for RLT and CAR T-cell therapy, which inherently require centralised designation and referral pathways. Regional budget pressures come with a risk of deprioritising innovative medicines and of widening inequities in access.



‘Innovation saves lives, but without strong governance, even the most powerful therapies can falter before they reach the patients who need them most.’  
MARK MCDONNELL

**Gaps in national cancer guidelines, combined with weak implementation planning, limit both the visibility and adoption of RLT.**

Although NCCP disease-specific cancer guidelines are under review, recent updates have focused on diagnosis, staging and active surveillance, with uncertainty over whether later-line therapies such as RLT will be explicitly addressed. Without explicit inclusion of later-line therapies and parallel investment in positron emission tomography (PET)/computed tomography (CT) imaging capacity, workforce and licensed facilities, RLT risks remaining aspirational rather than accessible.

**WHAT CAN BE DONE?**

- The upcoming independent review of the national cancer strategy provides a timely mechanism to ensure RLT is fully integrated into future planning for use in different types of cancer. A dedicated section should outline designated centres, referral pathways, workforce requirements, infrastructure needs and data capture through the National Cancer Registry. Nuclear medicine and radiology input is essential to avoid a narrow, disease-specific approach and to ensure planning is comprehensive and sustainable.
- The National Radioligand Therapy Advisory Group has only met once in over 18 months, but has significant potential.<sup>33</sup> It should be formally embedded in national cancer governance to lead service design, centre designation, workforce planning and phased expansion. With clear links to national strategy and funding, it can translate clinical expertise into coordinated system delivery and avoid ad hoc or inequitable roll-out.
- The Irish government should designate a clear national owner for RLT within cancer governance structures, such as within the NCCP or a reformed national cancer entity. This would address the current governance vacuum and support horizon scanning, cross-specialty coordination and long-term investment planning.
- Revisions to national cancer guidelines present an opportunity to embed RLT into routine practice and make them an option earlier in treatment pathways. Guidelines should also recognise the lower toxicity of RLT and potential to reduce reliance on costly repeat treatments such as radiotherapy. The ongoing revision of the NCCP prostate cancer guidelines provides scope to include RLT (in the new section on patient impact and clinical considerations), offering a clear route to articulate quality-of-life and survival benefits in line with European guidance. In parallel, national RLT service delivery guidance is needed to define delivery models, workforce roles, infrastructure requirements and radiation safety standards.<sup>34</sup>

**BEST-PRACTICE EXAMPLE 1****Preparing for RLT in national cancer plans: Spain**

The Spanish plan for implementing the EU Beating Cancer Plan includes funding for precision diagnostics and molecular imaging, critical for RLT.<sup>32</sup>

**Advancing regulation and reimbursement****WHY IS THIS IMPORTANT?**

Reimbursement and regulation are critical to translating innovative cancer therapies into real-world patient access. Systems are required to recognise the full cost and complexity of advanced therapies, beyond the drug alone, including imaging, workforce, facilities and follow-up.

**WHAT IS THE CURRENT CONTEXT?**

**The lack of public reimbursement for RLT in cancer has created a stark and ethically challenging two-tiered access system.** Despite EMA authorisation, RLT for certain cancers is unavailable. As a result, people can typically only access the therapy through self-funding, which is only possible for those with adequate disposable income. This stands in contrast to funded access to other advanced therapies, including CAR T-cell therapy and NET RLT, further compounding the inconsistency and inequity.

**Ireland's HTA, pricing and reimbursement processes are widely seen as too slow, opaque and fragmented.**

Approval timelines for new cancer medicines exceed targets, with limited transparency and ethical governance, no clear appeal or resubmission routes, and further delays created by unclear post-HTA steps. Reimbursement may also only be approved for people at specific stages of cancer. Yet once any reimbursement decision is made, even one that excludes most patients, alternative routes (such as treatment abroad and compassionate access) are closed off entirely, leaving people outside the approved criteria with no funded pathway and no fallback.

**Ireland's limited use of European regulatory and HTA outputs adds duplication and inefficiency.**

National bodies in Ireland repeat clinical assessments already completed by the EMA instead of focusing on cost-effectiveness and service impact. With the new EU HTA regulation aiming to streamline joint assessments for innovative medicines, this duplication is increasingly out of step. This is so especially for RLT, where complex delivery requirements make repeated national reviews particularly resource intensive.



'A breakthrough means nothing if our systems can't approve it, reimburse it or deliver it safely.'

PROFESSOR  
MARTIN O'CONNELL

### Current funding structures are poorly aligned with the delivery of national, highly specialist RLT services.

The planned regionalisation of budgets risks discouraging hospitals from establishing or expanding services without national funding protections. Funding is often focused narrowly on the radiopharmaceutical, rather than the full RLT pathway, including imaging, workforce, multidisciplinary team (MDT) coordination and long-term follow-up. Experts further highlighted that ‘money does not follow the patient’ when individuals travel for care, leaving receiving centres to absorb costs and discouraging out-of-region referrals. This reflects broader concerns about weakened national oversight following budget decentralisation.

#### WHAT CAN BE DONE?

- HTA and regulatory pathways for RLT should be redesigned to mandate nuclear medicine, radiology, radiation oncology, oncology, medical physics, radiopharmacy, radiation protection and patient input. They should align more closely with European frameworks, as current assessments do not reflect clinical realities or international practice. Advanced therapies such as RLT require differentiated appraisal pathways allowing iterative submissions and price renegotiation. They should better utilise EMA and EU joint clinical assessments as this would reduce duplication and allow national focus on cost-effectiveness, service readiness and affordability in Ireland.
- A specific national RLT (or advanced therapies) budget should be developed to enable coherent national planning. Also essential are managed early and compassionate access programmes for small or rare types of cancer, overseen by national expert advisory bodies, as well as reimbursement models that cover the full episode of care, including imaging, physics, staffing and follow-up, rather than the radiopharmaceutical alone.
- Ireland should pilot outcome based or conditional reimbursement models for RLT, using international experience to reduce financial risk while expanding access. For example, countries such as Germany have linked payment to patient response in the initial roll-out of CAR T-cell therapy.<sup>37</sup> Similar models in Ireland would enable staged investment in RLT and its infrastructure, while ensuring patients benefit sooner and more equitably.

#### BEST-PRACTICE EXAMPLE 2

##### Ensuring adequate hospital funding: Germany

German hospitals can apply for specific funding to cover high-cost innovative therapies not included in baseline funding. This means hospitals are not required to choose between whether to fund innovative medicines or other lower-cost therapies.<sup>35,36</sup>

#### BEST-PRACTICE EXAMPLE 3

##### Early access and reimbursement: France

France provides government-backed early access schemes (e.g. temporary authorisations) before full reimbursement.<sup>38</sup> This approach facilitates the organisation of services and allows people to access potentially life-saving therapies much earlier, reducing delays and improving equity of care while reimbursement decisions are finalised.

## Addressing identified patient need

#### WHY IS THIS IMPORTANT?



When strong epidemiological data are linked with insight into patient awareness and experience, services can be designed to be more responsive, equitable and prepared for growing demand.

#### WHAT IS THE CURRENT CONTEXT?

**Awareness of advanced cancer therapies such as RLT is low among people with cancer in Ireland, which exacerbates inequities in access and limits informed decision-making.** Many people are unaware that RLT exists and therefore do not seek it out as a treatment option. This leaves them at a disadvantage in understanding their potential choices, particularly when considering quality of life. Meanwhile, healthcare professionals described a moral dilemma, whereby the high, unfunded costs of RLT discourage them from raising it in consultations, even when clinically relevant. In the absence of trusted HSE information, people with cancer may rely on informal or unreliable sources, undermining shared decision-making and widening disparities in who accesses advanced therapies.

**Differences in awareness among healthcare professionals and limited formal training in advanced nuclear medicine contribute to under-referral and inconsistent access to RLT.** Comfort and familiarity with RLT varies widely across specialties and regions, and advanced therapies are not systematically embedded in core training curricula. As such, some clinicians may be unsure when RLT is appropriate or how to refer, while others may be reluctant to refer people to national or specialist centres, due to either perceived loss of ‘ownership’ or uncertainty about service availability.

#### WHAT CAN BE DONE?

- Plan for the expansion of RLT across multiple cancer tumour types alongside modernising national and local cancer data systems, with better linkage between registries, imaging, treatment and outcomes, to enable trend-based planning and more resilient service design.



‘I want a system that doesn’t just plan for treatments, but plans for the people who will need them. When health services truly listen to us, they can build care that feels prepared, fair and human.’

MARTIN SWEENEY

- Develop clear, neutral RLT information resources, hosted by trusted bodies such as the HSE or national charities, that explain eligibility, procedures, risks, benefits and funding status. Presenting RLT as an emerging therapy where appropriate can help set expectations, and support ethical, informed decision-making. Including these therapies in clinical guidelines would also help awareness.
- RLT and broader theranostics concepts (*Box 4*) should be incorporated into undergraduate medical education, postgraduate specialist training (oncology, nuclear medicine, radiology, urology, nursing, medical physics) and continuing professional development. Dedicated theranostics pathways and scaling existing initiatives, such as oncology nurse education programmes, are practical steps to improve early identification, referral consistency and national readiness.

#### BOX 4. Theranostics

Theranostics is a medical approach that links diagnosis and therapy, so the diagnostic test shows exactly where the cancer is and is used to guide the treatment to the correct places.

#### BEST-PRACTICE EXAMPLE 4

##### Increasing awareness among healthcare professionals: the Radioligand Therapy Academy

The Radioligand Therapy Academy, an online resource, seeks to increase knowledge of the therapy around the world and advance its integration into cancer care.<sup>39</sup>

The academy offers virtual and in-person courses, providing healthcare professionals with the opportunity to upskill in the field of RLT. This can in turn help increase referrals.

## Enhancing service provision

### WHY IS THIS IMPORTANT?



Assessing service capacity helps identify gaps and bottlenecks. It is central to delivering real access to advanced cancer therapies, which require specialist staff, infrastructure and coordinated multidisciplinary care to ensure services are scalable, sustainable and equitable as demand grows.

### WHAT IS THE CURRENT CONTEXT?

**Chronic workforce shortages and the lack of recognised training and career pathways are major barriers to the safe and timely expansion of RLT in Ireland.** Shortages in critical roles specifically trained in RLT (including radiologists, oncologists, nuclear medicine physicists, radiochemists, radiopharmacists, specialist nurses and administrative staff) are limiting capacity. For example, there are only 9.7 radiation oncologists per million people in Ireland compared with the European average of 12.8.<sup>40</sup> These challenges are compounded by the lack of formalised training programmes, accreditation standards or clear requirements for doctors delivering RLT.<sup>41</sup> Specialist nursing roles – essential for patient education, toxicity management and continuity of care – are difficult to sustain outside high-volume centres. Clinicians noted that with targeted investment in staffing, training and accreditation, the Irish health system has a real opportunity to prepare for RLT in a way that enables safe, scalable and sustainable access as demand grows.



‘Approval alone doesn’t save lives. Patients only benefit when we organise the people, facilities and pathways to deliver these therapies safely and consistently.’

DR MATHILDE COLOMBIÉ

**Ireland faces major bottlenecks in the RLT pathway due to limited molecular imaging capacity, outdated infrastructure and uncoordinated equipment planning.** Long waits for diagnostic PET scans, a shortage of radiotracers in key centres and too few public PET/CT scanners – there are only eight in Ireland – are delaying diagnosis and treatment.<sup>42</sup> Wider gaps in nuclear medicine facilities and workforce planning stem from the lack of national coordination. Ireland also has no public cyclotron or radiopharmacy infrastructure, leaving it without the integrated ecosystem seen in other EU countries. This is a striking gap given

Ireland's strong pharmaceutical sector and it highlights the need for coordinated action across health, education and science.

**RLT service provision in Ireland is highly centralised and fragmented, creating inequitable access for people living with cancer.** RLT for NETs is currently delivered at a single centre in Dublin, while other centres are technically capable but not operational. For example, RLT had previously been administered (in 2022–2024) under compassionate access at the Mater Misericordiae University Hospital.<sup>43</sup> In the absence of a defined national model, people – particularly those living in rural areas – face travelling long distances or seeking care abroad; radiation oncologists working in publicly funded hospitals are only located in three of the six HSE regions.<sup>40</sup> This inequitable service provision may also exclude people from relevant clinical trials, which directly undermines the national cancer strategy's goal of increasing clinical trial participation. Multistage referrals, inconsistent practices and funding arrangements that do not allow budgets to follow patients further delay access and discourage referral.

#### WHAT CAN BE DONE?

- National RLT-specific guidance should be developed, bringing together nuclear medicine, radiology, radiation oncology, medical oncology, specialist nursing, radiopharmacy, medical physics and administrative support, and including patient representatives to ensure fair allocation of limited treatment slots and to generate real-world data on demand and outcomes. Streamlining MDT processes, such as establishing regional MDTs or a single, national specialist MDT for complex cases with clear referral inputs, would reduce delays caused by multiple sequential discussions.
- Dedicated specialist roles should be utilised to increase capacity, quality and patient experience. Cancer nurses have key roles in education, side effect management, coordination and continuity of care and are essential as access expands. In parallel, expert radiochemists and radiopharmacists could train the next generation of Irish specialists, including through site visits, equipment advice and supervision of in-house production of radioactive treatments. But these roles require formal recognition, training pathways and regulation to scale safely.

#### BEST-PRACTICE EXAMPLE 5

##### Enhancing regional equity: Italy

If granted, advanced therapies in Italy must be available nationwide, overriding regional disparities. This is achieved by a central innovation fund that finances access to these therapies directly rather than through regional budgets.<sup>44</sup>

#### BEST-PRACTICE EXAMPLE 6

##### A training programme for specialist nurses: Poland

Poland strengthened its RLT workforce by creating a national specialist nurse training programme in 2019, addressing the previous lack of formal training programmes for nuclear medicine nurses.<sup>45</sup>

The national-level course shows how targeted national training can quickly build capacity. Expanding similar programmes to include other key professionals, such as radiopharmacists, would further support safe, scalable delivery of RLT.

- Formalise a national hub-and-spoke model for RLT, building on established good practice in NETs. A national RLT multidisciplinary team for NETs based at St. Vincent's University Hospital already links with centres in Cork and Galway, and with other referring clinicians, to review all RLT cases centrally. This model should be expanded and formalised so specialist hubs lead on RLT expertise, training and infrastructure, while spoke centres handle referral and follow-up through standardised MDT processes. This would support fair access nationwide and enable future cross-border collaboration.
- Develop a national RLT service framework, defining staffing, medical physics, imaging, space, safety and governance requirements. Standardised workforce ratios, service specifications and MDT templates would reduce duplication and prevent under-resourcing. Involvement in RLT-related clinical trials can help hospitals to build skills and test pathways before reimbursement, while appropriate use of outpatient delivery could expand capacity, ease pressure on inpatient beds and improve patient experience.

#### BEST-PRACTICE EXAMPLE 7

##### Hub-and-spoke: the British Nuclear Medicine Society

The British Nuclear Medicine Society proposed a hub-and-spoke model of service provision to ensure equitable access to RLT.<sup>46</sup>

This involves a central hub, equipped to deliver RLT, working in conjunction with spoke centres, which have fewer specialist staff but can rely on capacity and expertise from the central hub to deliver high-quality services.<sup>47</sup>

People on low incomes may be eligible for financial help with travel costs to access specialist services.<sup>48</sup>

## Improving health information and data

### WHY IS THIS IMPORTANT?



Strong health information systems and high-quality, interoperable registry data are essential to planning advanced cancer therapy services. They enable clinicians and system planners to see a complete picture of a patient's pathway, diagnosis, imaging, treatment and outcomes, regardless of where care was delivered.

### WHAT IS THE CURRENT CONTEXT?

#### **Ireland lacks reliable, up-to-date data on RLT need, making strategic planning and investment difficult.**

National Cancer Registry data are four to five years out of date and do not capture key RLT-relevant clinical details such as disease stage, metastatic progression or biomarker subtypes. There are no national cancer registries that can link data on health outcomes, quality of life or cost of treatment. Even basic information (such as PET/CT activity, scanner capacity or radiopharmaceutical use) is not routinely collected. As a result, healthcare professionals rely on rough estimates, while policymakers cannot accurately assess need, model future demand or generate the evidence required for HTA, guidelines or long-term service planning.

#### **Fragmented electronic health record systems and weak interoperability further undermine national oversight of RLT activity and outcomes.**

Hospitals often rely on multiple non-interoperable systems across radiology, laboratories and clinical notes, many of which do not connect between sites or regions. Even where electronic data exist, extracting basic information, such as how many patients received a specific treatment, often requires additional work. RLT depends on tightly coordinated imaging, MDT decision-making and routine, long-term follow-up, meaning this fragmentation prevents generating real-world evidence and obscures true system-level demand and capacity.



'Without connected data, we're planning services in the dark. Interoperability isn't a luxury – it's the backbone of safe, strategic cancer care.'

PROFESSOR LARRY BACON

### WHAT CAN BE DONE?

- Ireland should leverage existing disease-specific registries, strengthen the National Cancer Registry and coordinate real-world data collection across centres. The Movember-funded prostate cancer registry (IPCOR) offers a good example of an immediate platform that could be rapidly used to model current and future populations. Targeted enhancements to the National Cancer Registry, particularly to improve timeliness and clinical granularity, could also be transformative, with only modest investment required to extend these registries to capture RLT-relevant variables.
- Ireland should leverage existing imaging and digital infrastructure to improve national oversight of RLT activity and demand. Existing cross-site imaging visibility could be used to track RLT-relevant scans, monitor throughput and support coordinated care. Improved use of electronic health records, supported by AI-enabled analytics, could bridge gaps between clinician estimates and system-level data by extracting information on biomarkers, disease stage and prior therapies from fragmented systems. This would enable capacity planning and policy decisions without waiting for full electronic health record interoperability.

## Recommendations to build future-ready cancer care

**Ireland stands at a critical juncture: advanced cancer therapies offer unprecedented opportunities to improve survival and quality of life, but their successful integration requires coordinated national action.** By strengthening governance, reforming regulatory and reimbursement systems, understanding patient needs, expanding service capacity and investing in health information infrastructure, Ireland can ensure equitable and sustainable access to these transformative therapies.



**Recommendations for policymakers to build a future-ready cancer care system that meets the needs of people living with cancer in Ireland today and in the decades ahead:**

Establish a single, national leadership structure with formal responsibility for RLT planning to ensure joined-up governance and forward planning with clear authority, budget and accountability.

- Ensure the inclusion of clinical and system experts who have established experience in the delivery of RLT services.
- Lead long-term strategic planning for advanced cancer therapies, including RLT.
- Coordinate regional implementation and infrastructure, and ensure national-level consistency.
- Embed RLT explicitly into the upcoming cancer strategy with defined milestones and capacity planning.

Develop an RLT-specific regulatory and reimbursement pathway aligned with EMA/EU HTA, and informed by expert clinical input to support decision-making and streamline assessments.

- Recognise RLT as a combined technology and infrastructure modality.
- Automatically adopt EMA clinical assessments and EU HTA outputs, limiting further local review to local cost-effectiveness.
- Ensure multidisciplinary expert review and transparent decision-making timelines with embedded appeal mechanisms.

Establish managed access and early access programmes for advanced cancer therapies, including RLT, to bridge gaps beyond standard reimbursement pathways.

- Introduce formal, managed access or early access mechanisms for RLT for qualifying patients, particularly those with rare cancers or unmet clinical need.
- Allow structured, compassionate access while EMA licensing, EU HTA assessment or national reimbursement decisions are pending.
- Embed clear, clinical eligibility criteria defined by national expert multidisciplinary teams (MDTs).
- Align managed access with data collection requirements to inform future reimbursement, pricing and service planning decisions.

Introduce a coordinated national and specialist RLT workforce framework to address capability gaps and support safe scale-up.

- Embed RLT education across the clinical training continuum.
- Fund standardised RLT multidisciplinary teams at designated centres with protected time.
- Create a national blueprint for RLT cancer nurse specialist and/or advanced nurse practitioner roles to coordinate care pathways, provide education and patient oversight, and strengthen continuity of care.

Define a consistent national model to address fragmented services, imaging bottlenecks and referral variation.

- Designate lead hub(s) for administration and patient oversight, with spokes for referral, regional MDTs and follow-up.
- Standardise workforce models (nursing, medical physics, radiopharmacy, medical oncology, data management).
- Set minimum levels of imaging capacity.
- Define national referral criteria and MDT participation rules to ensure equitable access.

Develop linked, cancer-specific and RLT-specific patient registries to reduce reliance on population estimates and quantify unmet need.

- Capture incidence, prevalence, biomarker status, outcomes, adverse events, quality of life, economic data and stage distributions relevant to RLT.
- Model five- to ten-year demand aligned to population growth and evolving indications.
- Record outcomes for everyone treated with RLT in public and private settings.

# Appendix

Over the next decade, radioligand therapy is expected to expand substantially beyond its current use, driven by a rapidly growing pipeline and widening clinical indications.<sup>49</sup> Evidence suggests it is transitioning toward a standard component of cancer care; however, realising this at scale will depend on early investment in isotope supply, infrastructure and specialist workforce capacity.<sup>49</sup>

**Table A.** Infrastructure and service requirements for the delivery of radioligand therapy.<sup>50-52</sup>

Infrastructure domain	What is required
<b>Licensed nuclear medicine/radiology facility</b>	An authorised nuclear medicine/radiology department with regulatory approval to receive, store, handle, and administer therapeutic radioisotopes
<b>Shielded treatment rooms</b>	Lead-lined or otherwise radiation-shielded treatment rooms appropriate to the radionuclide used
<b>Appropriately shielded designated bathroom facilities and patient waste systems</b>	Dedicated, shielded toilets and controlled plumbing systems to manage radioactive excreta following treatment (particularly for inpatient or higher-dose RLT)
<b>Radioactive waste management</b>	Shielded decay-in-storage areas and protocols for radioactive solid and liquid waste prior to disposal
<b>Radiopharmacy</b>	Access to a hospital-based radiopharmacy with appropriate facilities for assay and administration of radiopharmaceuticals
<b>Radiopharmaceutical transport and logistics</b>	Licensed, secure transport systems enabling time-critical delivery of radioligands from manufacturing or radiopharmacy sites
<b>Diagnostic imaging</b>	PET/CT and/or SPECT/CT scanners are needed to check if a patient is suitable for treatment, to help plan the treatment and to monitor how well it is working
<b>Specialist workforce</b>	Trained nuclear medicine physicians or radiologists with nuclear medicine sub-specialisation, oncologists, radiochemists/radiopharmacists, medical physicists, radiographers, specialist nursing staff and administrative staff
<b>Inpatient or day-case treatment capacity</b>	Designated beds or day-case chairs with appropriate radiation controls, depending on isotope, dose and national regulation
<b>Multidisciplinary care structures</b>	Formal referral and decision-making pathways linking oncology, nuclear medicine, radiology, urology/endocrinology and nursing

SPECT, single-photon emission computed tomography.

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