dQ&A Prescriber Perspectives – Case Study

Will GLP-1s replace insulin? - Yes and No

An AI-powered deep dive into two years of therapy transition data in U.S. adults with Type 2 diabetes finds that GLP-1 receptor agonists are both finding their place early in the patient journey and also being layered onto existing insulin regimens.

The narrative around GLP-1 receptor agonists has grown increasingly bold. GLP-1 prescriptions have grown dramatically since 2021, driven by semaglutide and tirzepatide's strong clinical profiles across glycemic control, weight loss, and cardiovascular outcomes. As adoption has accelerated, a natural question has emerged: will GLP-1s displace insulin in the type 2 patient journey, or expand the treatment footprint, or both?

To understand this better, we turned to our US Patient Voice data: 15 years of longitudinal patient experience data gathered from 6,000 diabetes patients and updated every three months. Our AI Research Platform makes complex cohort analyses immediately available to our analysts and our clients, and we took full advantage of it to dive deep into the data for the last two years.

For the analysis, we tracked 2,491 Type 2 diabetes patients across four mutually exclusive therapy groups defined in Q1 2024:

- Insulin Only (22%)
- GLP-1 Only (26%)
- GLP-1 + Insulin (21%)
- Neither GLP-1 nor Insulin (31%).

We then re-classified each participant's therapy status in Q2 2026, roughly two years later, to see where they ended up. This isn't two similar samples from two different surveys, it's the same patients answering the same questions.

Insulin only: the augmentation story

The clearest finding comes from the Insulin Only cohort. If GLP-1s were displacing insulin, we would expect a meaningful share of these patients to have dropped insulin and moved to GLP-1 monotherapy. That is not what happened. Just 2.3% made that switch (true displacement) compared to 21.0% who added a GLP-1 on top of their existing insulin, moving to GLP-1 + Insulin. Augmentation was nine times more common than true displacement. When insulin

patients encounter GLP-1s, the dominant clinical response has been to add, not swap out one drug for another.

Insulin + GLP-1: the two-way street

Among patients already on both therapies, the picture is one of relative stability with modest, symmetric attrition in both directions. Of the GLP-1 + Insulin cohort, 9.6% dropped insulin (moving to GLP-1 Only) while 11.9% dropped GLP-1 (moving to Insulin Only): a difference that is not statistically significant at the 90% confidence level. There is no directional signal here favoring one drug class over the other when patients are already on both.

GLP-1 only: stable category, churning brands

The GLP-1 Only cohort was the most stable of all four groups, with 85.2% remaining on a GLP-1 in Q2 2026. The main exit route was discontinuation rather than escalation to insulin: 9.6% dropped the GLP-1, while only 1.9% added insulin. GLP-1 therapy, once established, appears durable, although the class-level stability masks plenty of churn at the brand level: almost 40% of patients switched brand over the two years.

Neither GLP-1 nor Insulin: GLP-1s winning the escalation decision

The most striking finding is among patients on neither insulin nor GLP-1 at baseline. Most of this group (82%) were taking oral diabetes drugs, marking this group as a distinct treatment tier, not patients where were brand-new to diabetes management.

Over the two-year period, 17.2% of this cohort started a GLP-1 compared to just 4.4% who started insulin — a fourfold difference. When oral-therapy patients need additional help, GLP-1 is the clear preferred next step.

What this means

The displacement thesis, as commonly framed, overstates what is actually happening in the real world over this two-year window. Established insulin users are not abandoning their regimens. Instead, GLP-1s are expanding the treatment footprint — adding a second agent rather than replacing the first. The insulin market is not being eroded from within, but it is being outpaced at the point of escalation from oral therapy.

Clinician perspectives bear this out. In our 2026 US Prescriber Perspectives study of 700 US diabetes prescribers, 54% of endocrinologists and 70% of PCPs told us that GLP-1s ‘very often’ or ‘often’ delay or replace progression to insulin therapy for their Type 2 patients.

For insulin producers, a resilient installed base is somewhat reassuring, but not sufficient. Few patients may leave, yet out data suggest that fewer future patients may arrive.

Weekly basal insulin offers one response. Our Awiqli: First Look real-world research with patients in Canada, where it has been available for some time, shows better A1C outcomes and a reduced treatment burden that patients very much appreciate. The addition pattern we see in our cohort analysis also strengthens the commercial rationale for simpler regimens combining insulin and a GLP-1. Weekly basal insulin could make the insulin component less

burdensome, including when added to an existing GLP-1. But switching a company's own daily-insulin customers creates value only if better retention, competitive gains or pricing outweigh cannibalization.

Oral GLP-1s could also intensify competition further upstream. Their appeal is that patients can enter the class without beginning injections. That could reinforce GLP-1s' lead at treatment intensification and postpone insulin initiation for some patients. Yet a pill does not automatically solve persistence. Daily dosing, tolerability, affordability and access still matter. In the panel, 9.6% of patients initially taking a GLP-1 without insulin ended up taking neither class. Winning the first prescription and retaining the patient are separate achievements.

For companies spanning both markets, the opportunity is to serve successive treatment needs: oral GLP-1s earlier, injectable options where appropriate, and more convenient insulin when additional control is required.

The strategic distinction, then, is between the stock of patients already taking insulin and the flow of patients approaching it. Weekly insulin can compete for the former and make treatment easier for the latter. Oral GLP-1s may reshape that flow before insulin is considered. Businesses in both classes should plan for coexistence without mistaking it for protection from competition.

Get the European perspective on this story from the prescriber point of view.

About the research: *Analysis performed using dQ&A's AI Analytics Platform, based on 2,491 Type 2 diabetes patients from the dQ&A US Patient Voice panel who responded between Q1 2024 and Q2 2026. All comparisons use 90% confidence intervals.*

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