dQ&A Prescriber Perspectives – Case Study

GLP-1s are changing insulin's timetable, but not displacing it

European prescribers expect later insulin starts. That's not the whole story.

For insulin manufacturers, the rise of GLP-1 therapies poses a question of timing as well as demand. Many European clinicians expect the drugs to postpone insulin initiation, sometimes by years. Yet their current practice – and our deep patient experience data - reveals a substantial population using both treatments. The commercial consequences depend on how these two developments interact.

dQ&A's 2026 EU5 Prescriber Perspectives report, covering Britain, Germany, France, Spain and Italy, captures that tension. Among surveyed endocrinologists treating non-insulin type 2 patients with GLP-1s, 38% expect the drugs to delay insulin initiation by more than two years. Another 20% expect them to prevent most such patients from needing insulin altogether. Among primary care physicians treating the same type of patient, the corresponding figures are 35% and 26%. Only 10% of endocrinologists and 6% of PCPs expect no effect on future insulin requirements.

But roughly half of endocrinologists' type 2 patients on a GLP-1 are also on insulin. In primary care, the proportion is four in ten. Those findings draw attention to today's reality: combination treatment is widespread in a market often discussed in terms of insulin's potential displacement.

Postponement and prevention have different commercial implications. A delay could change the timing of insulin starts and the needs of patients who eventually require it. Permanent avoidance would remove some future users.

It does, however, show that combination treatment already has a substantial place. Endocrinologists estimate that, on average, 53% of their type 2 GLP-1 patients also take insulin. PCPs estimate slightly lower, at 40%. These are averages of clinicians' estimates within their practices, rather than national market shares. They nevertheless align closely with our data from our ongoing twice-yearly EU Patient Voice Study, where just under half of Type 2 GLP-1 patients tell us that they are also on insulin.

Clinical evidence helps explain the overlap. The joint American Diabetes Association and European Association for the Study of Diabetes consensus report, published on October 2, 2026, describes greater glucose-lowering efficacy from combining basal insulin with a GLP-

1 receptor agonist than from either component alone. It also identifies advantages in weight gain and hypoglycemia compared with intensified insulin regimens.

The guidance gives a clinical rationale for the coexistence seen in the survey, without resolving how the balance between treatments will evolve across individual European healthcare systems.

Trials underscore the point. SUSTAIN 5 studied 397 adults whose type 2 diabetes was inadequately controlled. Adding semaglutide to basal insulin reduced HbA1c and body weight more than adding placebo over 30 weeks. Discontinuation because of adverse events was more frequent with semaglutide, mainly because of gastrointestinal effects.

SURPASS-6 addressed the next treatment decision in 1,428 adults already on basal insulin. Adding tirzepatide, a dual GIP/GLP-1 receptor agonist, produced greater HbA1c reduction, weight loss and fewer hypoglycemic events than adding mealtime insulin lispro over 52 weeks. Gastrointestinal symptoms were tirzepatide's most common adverse events. The trial illustrates how incretin-based therapy can change insulin intensification; but it does not establish permanent insulin avoidance.

For manufacturers, the implication is a more differentiated treatment pathway. Insulin companies need to understand when clinicians still consider insulin necessary and how they manage it alongside GLP-1s.

Weekly insulin dosing presents a clear opportunity. Our qualitative and quantitative research with Awiqli users in Canada, where it has been available for a while, linked Awiqli patients' experiences directly to their health record data. We saw strong A1C outcomes combined with reduced patient burden and high therapy satisfaction.

It's clear that both GLP-1 and insulin manufacturers have an important audience among clinicians caring for existing insulin patients. CGM manufacturers and diabetes data companies might also investigate what support they need to navigate the regimen change successfully. The ADA's 2026 Standards of Care recommend reassessing insulin dosing when a GLP-1 or dual GIP/GLP-1 therapy is added or its dose increased. Treatment adjustment creates a need for careful management and monitoring.

Practical constraints will determine how far prescribers' expectations translate into treatment. In dQ&A's EU survey, 47% of endocrinologists rate side effects as a moderate or major barrier to GLP-1 prescribing, and 45% say the same about patient cost. Only 25% express concerns about long-term efficacy.

The strategic task is to understand these transitions: who starts insulin later, who continues it alongside a GLP-1, and whose insulin regimen becomes less intensive. Companies that follow those decisions closely will have a clearer view of the market than those counting the therapies as separate patient populations.

Go deeper? Here's our analysis of two years of US Insulin and GLP-1 patient experience data.

About the research: *dQ&A surveyed 684 eligible healthcare professionals across EU5 during July–August 2026: 253 endocrinologists/diabetologists, 176 diabetes nurse educators/specialists and 255 PCPs. Recruitment was based on patient base and diabetes technology prescribing criteria. Topics covered included GLP-1s and the type 2 patient journey, technology experience and preferences (insulin pump/AID systems, CGM systems, diabetes data software), and experiences with manufacturers' representatives.*

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