Australian Government

Department of Health, Disability and Ageing

Interim Australian Centre for Disease Control

Australian Respiratory Surveillance Report

Key messages

This report presents a national epidemiological update for acute respiratory infections, including coronavirus disease 2019 (COVID-19), influenza and respiratory syncytial virus (RSV), with a focus on the current reporting period (22 September to 5 October 2025) and earlier severity reporting periods (up to 21 September 2025).

In the community: In the last fortnight, influenza-like illness among national helpline callers and the rate of helpline callers referred to seek urgent medical care both decreased slightly compared to the previous fortnight. Self-reported new fever and cough symptoms among community survey participants was comparable to the previous fortnight and slightly fewer community survey participants reported taking time off work due to respiratory illness. Nationally, COVID-19 cases continued to decrease in the last fortnight and remain lower than at the same time in previous years. Influenza cases decreased in all jurisdictions the last fortnight; however, national influenza case numbers were higher than observed at the same time in previous years. This can be attributed to a prolonged peak in between late June to mid-August 2025, and a slower decrease in case numbers than observed in previous seasons. RSV cases continued to decrease in the last fortnight, continuing the downward trend in national case numbers observed since mid-July 2025.

In general practice: In the last fortnight, there were fewer general practice consultations with influenza-like illness (defined as new fever and cough symptoms) at sentinel surveillance sites than in the previous fortnight. Since late June 2025, influenza-like illness consultation rates have exceeded the five-year average but have continued the similar downward trend observed at the same time last year.

In hospitals: Sentinel hospital-based surveillance indicates that admissions with severe acute respiratory infections have been decreasing since a peak in late June 2025. The proportion of patients who were admitted directly to intensive care at a sentinel hospital site remains low. At sentinel hospitals, a similar number of children (those aged 16 years and younger) were admitted with influenza or RSV than with COVID-19. In contrast, more adults were admitted with COVID-19 compared to influenza or RSV. Sentinel intensive care surveillance shows that intensive care admissions with severe acute respiratory infections have been declining since late June 2025. In the year to date, most patients were admitted with influenza. A higher proportion of intensive care admissions with influenza and parainfluenza required invasive mechanical ventilation. The duration of intensive care stay is relatively similar between illnesses. In the last fortnight, the average number of COVID-19 cases occupying intensive care beds was similar to the previous fortnight and the average number of intensive care staff unavailable due to illness decreased.

Deaths: COVID-19 has remained the leading cause of acute respiratory infection mortality across 2023–2025. All three of these acute respiratory infections are more likely to cause death in older age groups than younger age groups.

In laboratories: In the fortnight, test positivity for SARS-CoV-2, influenza and RSV decreased slightly. The SARS-CoV-2 variant under monitoring, NB.1.8.1, is the dominant SARS-CoV-2 variant in the last 28 days (8 September to 5 October 2025) accounting for 52.3% of sequences in Australia.

Vaccine coverage, effectiveness and match: Nationally, fewer adults have received a COVID-19 vaccine in the last 12 months compared to the 12 months prior. Influenza vaccine coverage is 30.6% this year, lower than at the same time in 2023 or 2022. Since the commencement of the National RSV Mother and Infant Protection Program, 132,053 Abrysvo doses have been administered. In the last six months, nirsevimab uptake is 20% nationally. Initial Australian studies suggest that in 2025, vaccinated individuals are roughly 53% less likely to attend general practice or be hospitalised with influenza than unvaccinated people. Of influenza isolates characterised in 2025 thus far, over 99% have been a good match to the corresponding 2025 vaccine components.

Australian Respiratory Surveillance Report

This report was prepared by Ash Donovan, Lauren Kutzner, Suzie Whitehead, Algreg Gomez and Caitlin Trenorden on behalf of the interim Australian Centre for Disease Control. We thank the staff and participants from the surveillance systems who contribute data for acute respiratory illness surveillance across Australia.

The report presents a national overview of acute respiratory infections in Australia, drawing information from several different surveillance systems. These surveillance systems help us to understand the distribution of acute respiratory illnesses in the community, the severity of infections including which populations might be at risk, and the impact of acute respiratory illnesses on the community and health system in Australia.

Surveillance indicators presented in this report are based on the Australian National Surveillance Plan for COVID-19, Influenza, and RSV. Please refer to the Technical Supplement – Australian Respiratory Surveillance Report for information on our surveillance sources and data considerations, including the considerable impact of the COVID-19 pandemic on acute respiratory infection surveillance in Australia. A summary of data considerations for this report are provided below:

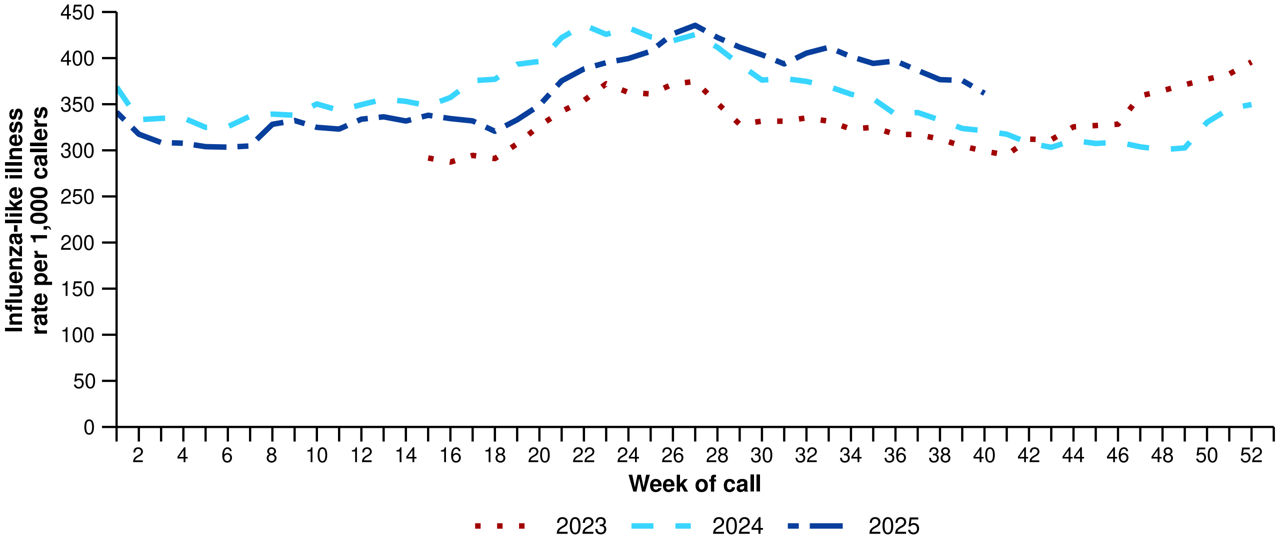
- Due to the dynamic nature of the surveillance systems used in this report, surveillance data are considered preliminary and subject to change as updates are received, with the most recent weeks considered particularly incomplete. Data in this report may vary from data reported in other national reports and reports by states and territories.
- Data in this report are presented by date of event (diagnosis, admission or death) or by the International Organization for Standardization (ISO) week date system, with weeks defined as seven-day periods which begin on a Monday and end on a Sunday. The ISO week date system is used to support trends comparisons over time more effectively. The current reporting period includes 22 September to 5 October 2025 and where comparisons to the previous fortnight are made, this includes 8 September to 21 September 2025.
- In Australia, states and territories (the Australian Capital Territory [ACT], New South Wales [NSW], the Northern Territory [NT], Queensland [Qld], South Australia [SA], Tasmania [Tas], Victoria [Vic] and Western Australia [WA]) report notified cases to the **National Notifiable Diseases Surveillance System (NNDSS)** based on the Australian national surveillance case definitions. NNDSS data are analysed and reported based on diagnosis date, which is the true onset date of a case if known, otherwise it is the earliest of the specimen date, the notification date or the notification received date. The NNDSS data for this report were extracted on 8 October 2025.
- To account for the lag in collection and provision of severity data from some surveillance systems, and for the time delay between illness onset and the development of severe disease outcomes, cases with an admission date or a diagnosis date in the last two weeks are excluded from severity analyses for hospitalisations and intensive care admissions. As such, the severity reporting periods are two weeks behind the end of the current reporting period. For this report, severity reporting includes data from 8 September to 21 September 2025 unless specified otherwise. Where comparisons to the previous severity fortnight are made this includes 25 August to 7 September 2025.
- Death registrations from the Australian Bureau of Statistics (ABS) Provisional Mortality Statistics are now used as the primary data source for measuring acute respiratory infection associated deaths. The ABS mortality data is sourced from the Registry of Births, Deaths and Marriages and is separate from the NNDSS. Registration-based mortality data needs time to be received and processed. For this reason, mortality statistics in this report may lag by at least two months.
- Analysis and reporting outputs were produced using R Statistical Software v4.3.1. While every care has been taken in preparing this report, the Australian Government Department of Health, Disability and Ageing does not accept liability for any injury or loss or damage arising from the use of, or reliance upon, the content of the report or Technical Supplement. For further information about this report refer to the Technical Supplement – Australian Respiratory Surveillance Report or contact respiratory.surveillance@health.gov.au.

Community surveillance

Community surveillance monitors respiratory illnesses in the community, providing information on the number of people reporting respiratory symptoms, testing practices, and the impact of respiratory illnesses. Community surveillance includes notification data obtained from laboratory tests for infections. Infections that are diagnosed and notified are only a subset of the total number of infections occurring in the community.

- In the last fortnight (22 September to 5 October 2025), there were slightly fewer Healthdirect helpline callers with influenza-like illness (369 per 1,000 callers per fortnight) than in the previous fortnight (382 per 1,000 callers per fortnight) (Figure 1).
- A gradual downward trend in the rate of influenza-like illness among helpline callers has been observed following a peak in late June 2025. Since late June 2025, the rate of influenza-like illness among helpline callers has been higher than the rate of influenza-like illness at the same time in 2024 and 2023 (Figure 1).

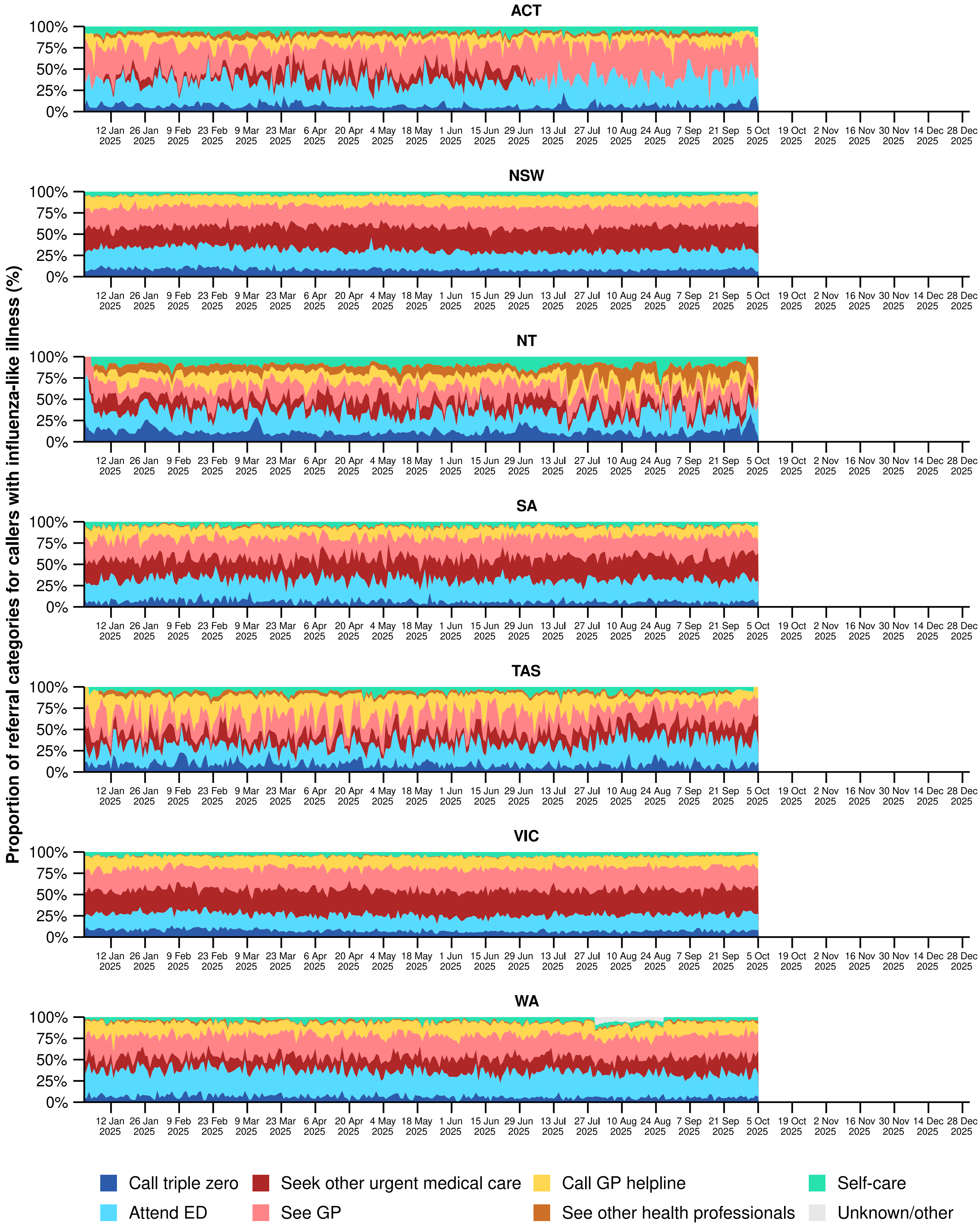
Figure 1: Rate of influenza-like illness per 1,000 helpline callers by year and week of call*, Australia†, 22 March 2023 to 5 October 2025



Source: Healthdirect Australia
* Healthdirect data prior to 22 March 2023 are unavailable as prior to this date a different data collection method was used.
† The Healthdirect helpline operates in all states and territories except Qld; therefore influenza-like illness trends will not be representative of Qld and may be underrepresented. See the Technical Supplement for more information.

- In the last fortnight, there were slightly fewer Healthdirect helpline callers with influenza-like illness referred to seek urgent medical care (190 per 1,000 callers per fortnight) than in the previous fortnight (194 per 1,000 callers per fortnight) (Figure 2).
  - Callers referred to seek urgent medical care include those referred to call triple zero, attend a hospital emergency department, contact a virtual emergency department, urgent care clinic or see a general practitioner within two hours.
- In the last fortnight, referral pathways for influenza-like illness varied across Australian jurisdictions. NSW, SA and Vic had the highest proportion of callers referred to see a general practitioner (GP) or seek other urgent medical care (Figure 2). By comparison, the ACT, the NT and Tas had a higher proportion of callers who were recommended to attend a hospital emergency department or call triple zero; whilst WA had similar proportions of callers referred to see a GP or other urgent medical care compared to callers who were recommended to attend a hospital emergency department or call triple zero. These differences may reflect variations in healthcare access and service models, and should be interpreted with caution (Figure 2).

Figure 2: Proportion of referral categories* for helpline callers with influenza-like illness by jurisdiction† and call date, Australia, 1 January to 5 October 2025



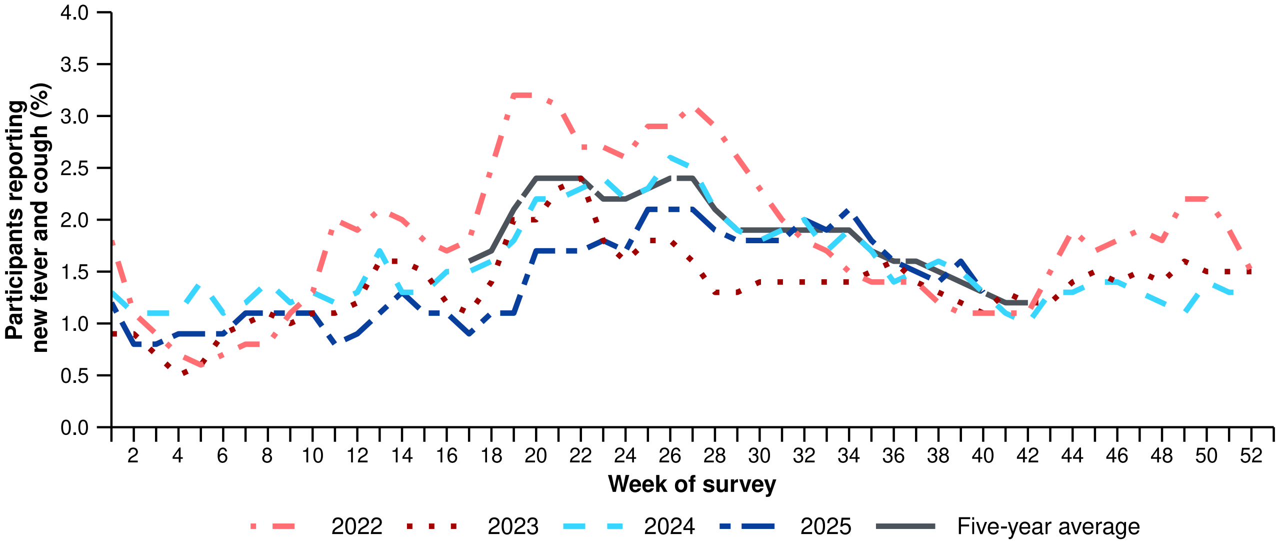
Source: Healthdirect Australia

* See other health professionals category includes pharmacist, dentist, mental health provider, primary maternity care, poison information centre or other.

† The Healthdirect helpline operates in all states and territories except Qld; therefore influenza-like illness referral trends are not provided for Qld. See the Technical Supplement for more information.

- In the last fortnight, the percentage of FluTracking survey participants who reported new fever and cough symptoms (1.5%) was comparable to the previous fortnight (1.4%) (Figure 3).
- In the last fortnight, more survey participants with new fever and cough symptoms used a rapid antigen test (RAT) (49.2%; 394/800) than a polymerase chain reaction (PCR) test (12.0%; 96/800) to test for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
- Self-reported SARS-CoV-2 RAT positivity was lower in the last fortnight (11.7%; 46/394) than in the previous fortnight (14.7%; 74/505). Comparatively, self-reported SARS-CoV-2 PCR positivity was higher in the last fortnight (9.4%; 9/96) than in the previous fortnight (5.8%; 8/137).
- In the last fortnight, 11.4% (91/800) of survey participants with new fever and cough symptoms used a PCR test to test for influenza. Self-reported influenza PCR positivity was slightly lower this fortnight (26.4%; 24/91), than in the previous fortnight (26.5%; 35/132).
- In the last fortnight, slightly fewer survey participants reported taking three or more days off work or normal duties due to fever and cough symptoms (42.8%; 342/800), than in the previous fortnight (45.6%; 454/996).
- An overall decreasing trend in the weekly percentage of FluTracking participants reporting new fever and cough symptoms has been observed since June 2025, with the weekly percentage relatively similar to the trends observed at the same time in 2024 and the five-year average (Figure 3).

Figure 3: Age standardised percentage of survey participants reporting new fever and cough symptoms compared with the five-year average* by year and week of survey, Australia, 2022 to 5 October 2025



Source: FluTracking
* From 2020, FluTracking expanded their data capture period to year-round. Data before May and after October for any year before 2020 are not available for historical comparisons. The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2018 to 2019 and 2022 to 2024. Please refer to the Technical Supplement for interpretation of the five-year average.

- In the last fortnight (22 September to 5 October 2025), there was a 25.2% decrease in COVID-19 cases, a 30.3% decrease in influenza cases, and a 33.5% decrease in RSV cases.

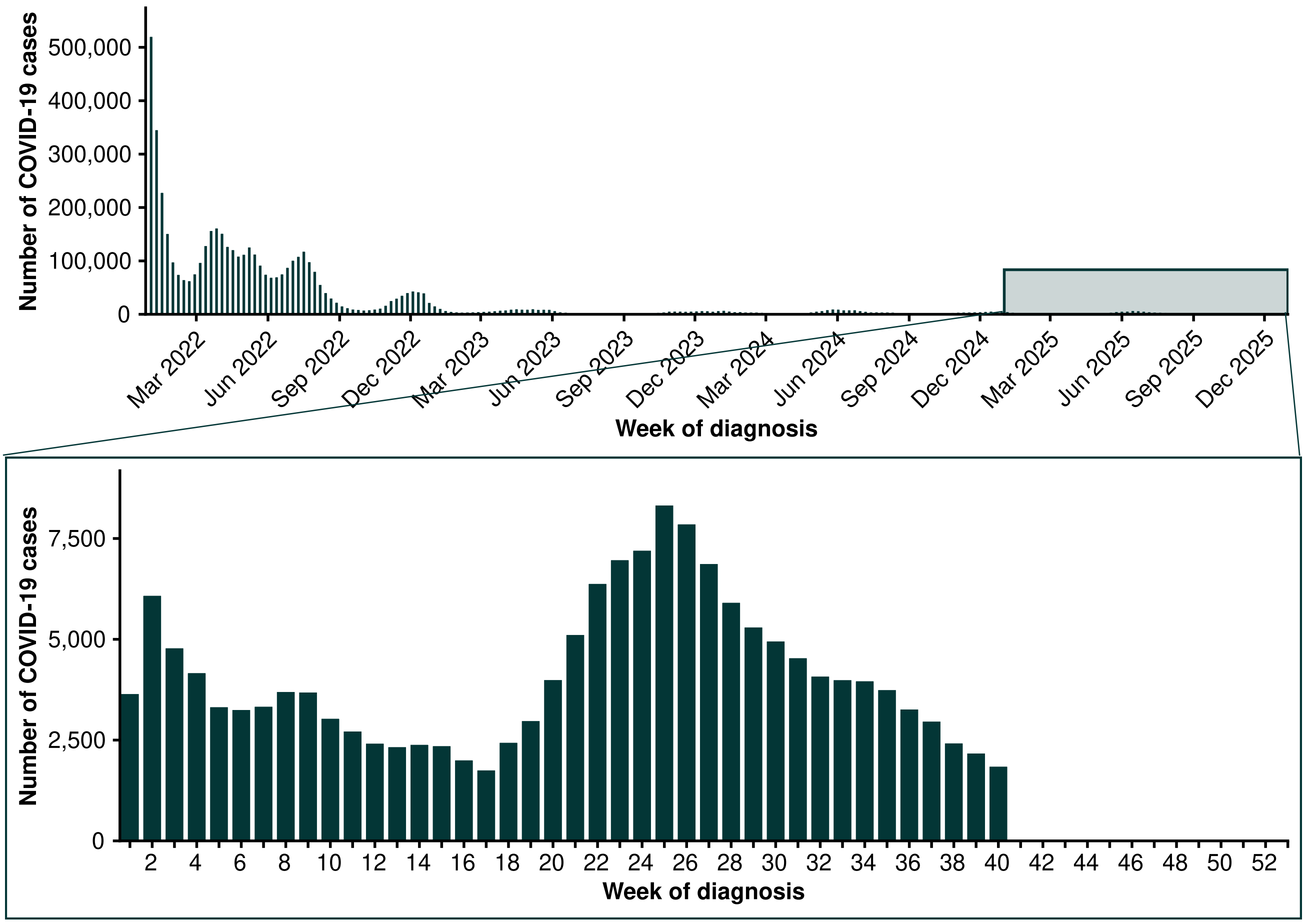
Table 1: Notified cases and notification rate per 100,000 population by disease, five-year age group, and jurisdiction*†, Australia, 1 January to 5 October 2025

	COVID-19			Influenza			RSV		
	Reporting period (n)	Year to date (n)	Year to date (rate)	Reporting period (n)	Year to date (n)	Year to date (rate)	Reporting period (n)	Year to date (n)	Year to date (rate)
Age group (years)									
0–4	528	15,940	1,056	2,241	46,495	3,082	1,599	73,178	4,850
5–9	148	4,722	293	2,760	57,791	3,587	376	12,226	759
10–14	140	5,033	301	2,100	40,685	2,430	189	5,414	323
15–19	125	5,446	328	1,541	24,704	1,486	143	3,582	215
20–24	147	5,583	312	1,066	13,990	782	124	2,826	158
25–29	184	6,949	348	939	13,501	676	110	3,332	167
30–34	207	8,377	411	1,038	18,952	929	139	4,262	209
35–39	233	9,612	484	1,191	25,328	1,276	130	4,307	217
40–44	228	9,224	498	1,084	25,606	1,383	142	3,812	206
45–49	201	7,894	485	864	19,834	1,218	144	3,541	217
50–54	197	7,945	470	821	17,967	1,063	178	4,390	260
55–59	200	7,674	501	656	16,107	1,051	201	4,757	310
60–64	195	8,207	535	662	15,693	1,023	216	5,379	351
65–69	212	8,474	623	655	14,095	1,037	237	5,609	413
70+	1,112	51,942	1,555	2,316	46,936	1,405	1,092	23,858	714
Jurisdiction									
ACT	69	2,632	555	282	7,441	1,569	65	2,809	592
NSW	1,796	73,316	864	6,910	148,919	1,755	1,407	66,352	782
NT	63	1,227	481	158	3,858	1,512	30	777	305
Qld	751	34,341	615	3,407	81,388	1,457	1,162	29,393	526
SA	265	9,980	531	1,652	28,325	1,508	629	11,727	624
Tas	82	2,491	433	550	6,787	1,180	135	2,583	449
Vic	827	28,464	408	4,702	91,485	1,310	1,029	35,421	507
WA	211	10,704	361	2,276	29,708	1,002	563	11,426	385
Total	**4,064**	**163,155**	**600**	**19,937**	**397,911**	**1,463**	**5,020**	**160,488**	**590**

Source: National Notifiable Diseases Surveillance System (NNDSS)
* Rate per 100,000 population for the given time period. Population data are based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) for the reference period June 2024, released 12 December 2024.
† Total includes cases with missing age.

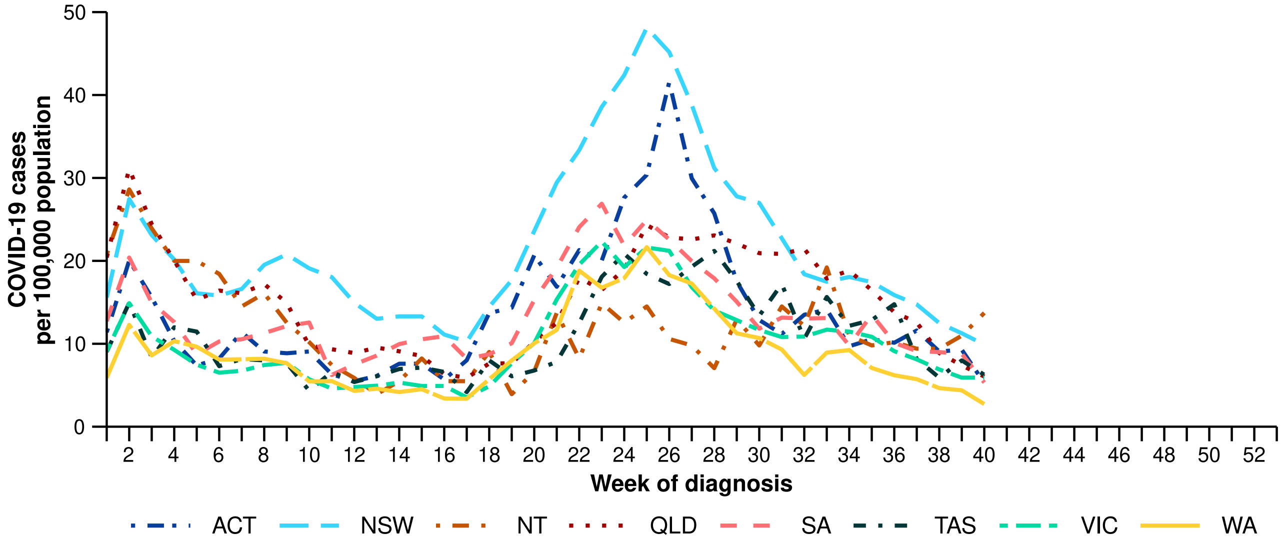
- In the last fortnight, nationally the number of COVID-19 cases reported each week continued to decrease following a peak in late June (Figure 4).
- The number of COVID-19 cases this year to date (n=163,155) is 30.9% fewer than the number of cases observed in the same time period last year (n=236,079) (Figure 4).
- In the last fortnight, COVID-19 notification rates decreased or remained relatively stable across all jurisdictions with the exception of the NT where an increase in notification rates were observed compared with the previous fortnight (Figure 5).
- In the year to date, COVID-19 notification rates remain highest in people aged 70 years or over, likely due to higher case ascertainment from targeted testing strategies for populations at-risk of severe disease or who live in a high-risk setting such as a residential aged care home (Table 1).
- In the year to date, COVID-19 notification rates are highest in NSW and lowest in WA (Table 1).

Figure 4: Notified COVID-19 cases (laboratory-confirmed only) by year and week of diagnosis, Australia, 2022 to 5 October 2025



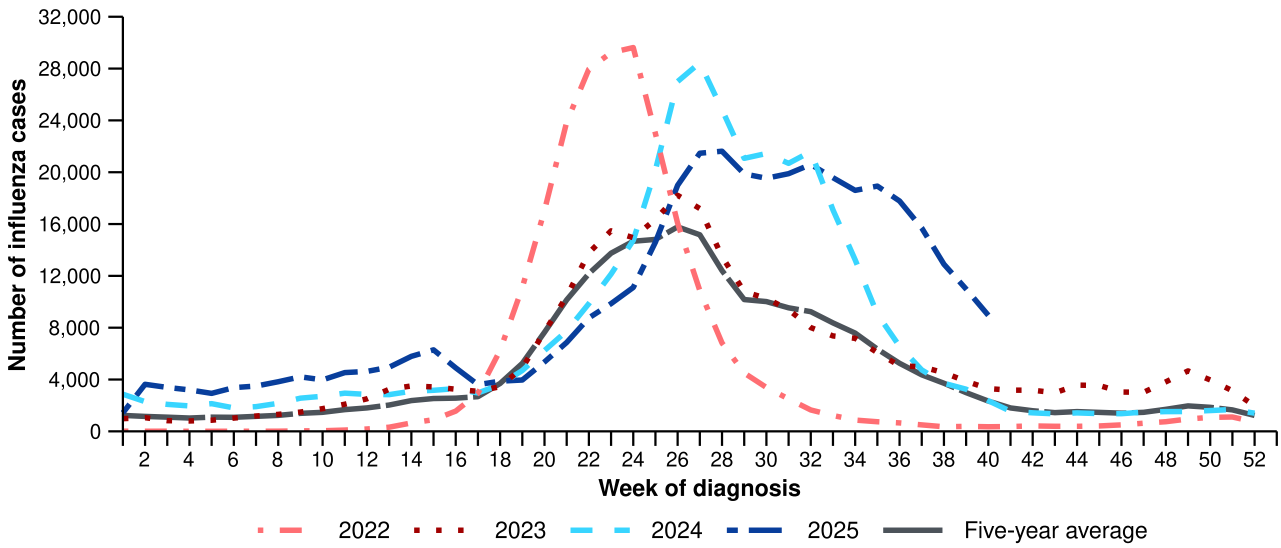
Source: National Notifiable Diseases Surveillance System (NNDSS)

Figure 5: Notification rates* per 100,000 population for COVID-19 cases by state or territory and week of diagnosis, Australia, 1 January to 5 October 2025



Source: National Notifiable Diseases Surveillance System (NNDSS)
* Rate per 100,000 population for the given time period. Population data are based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) for the reference period June 2024, released 12 December 2024

Figure 6: Notified influenza cases and five-year average* by year and week of diagnosis, Australia, 2022 to 5 October 2025

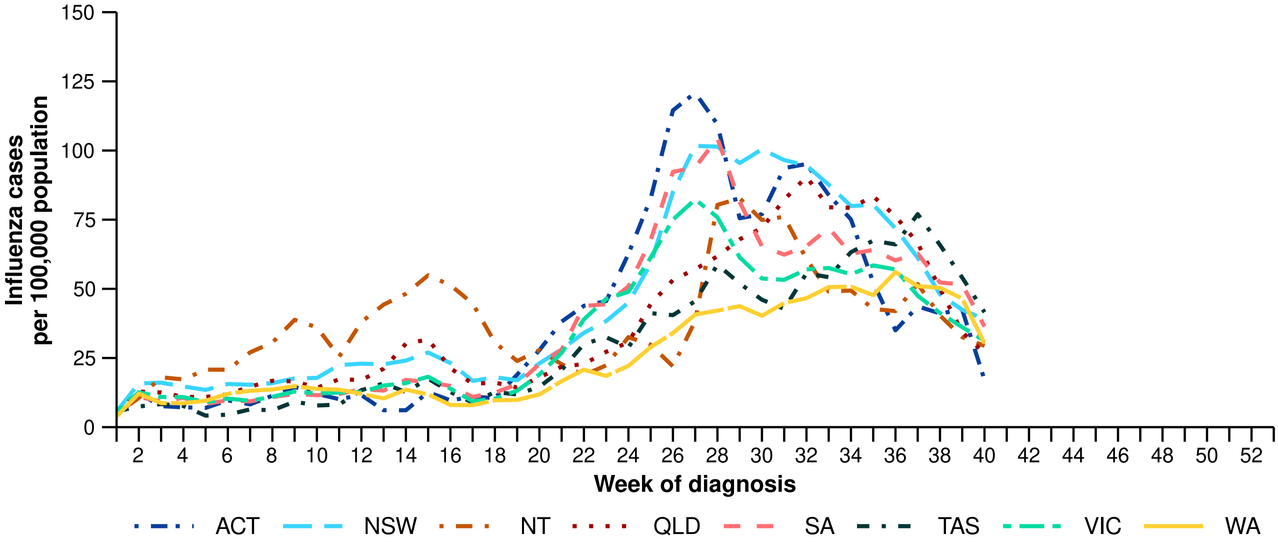


Source: National Notifiable Diseases Surveillance System (NNDSS)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2018 to 2019 and 2022 to 2024. Please refer to the Technical Supplement for interpretation of the five-year average.

- In the last fortnight, the number of influenza cases nationally decreased; however, influenza case numbers in the last fortnight remain higher than observed at the same time in previous years (Figure 6). This can be attributed to a prolonged peak in between late June to mid-August 2025, and a slower decrease in case numbers than observed in previous seasons (Figure 6).
- The number of influenza cases this year to date (n=397,911) is 14.6% more than the number of cases observed in the same time period last year (n=347,179) (Figure 6).
- In the last fortnight, a decrease in influenza notification rates was observed across all jurisdictions compared with the previous fortnight (Figure 7). In the last fortnight, a steeper declining trend was observed in the ACT, Qld, SA, and WA compared to NSW, the NT and Vic (Figure 7).

- In the year to date, influenza notification rates remain highest in children aged 5–9 years and children aged 0–4 years (Table 1).
- In the year to date, influenza notification rates are highest NSW and lowest in WA (Table 1).

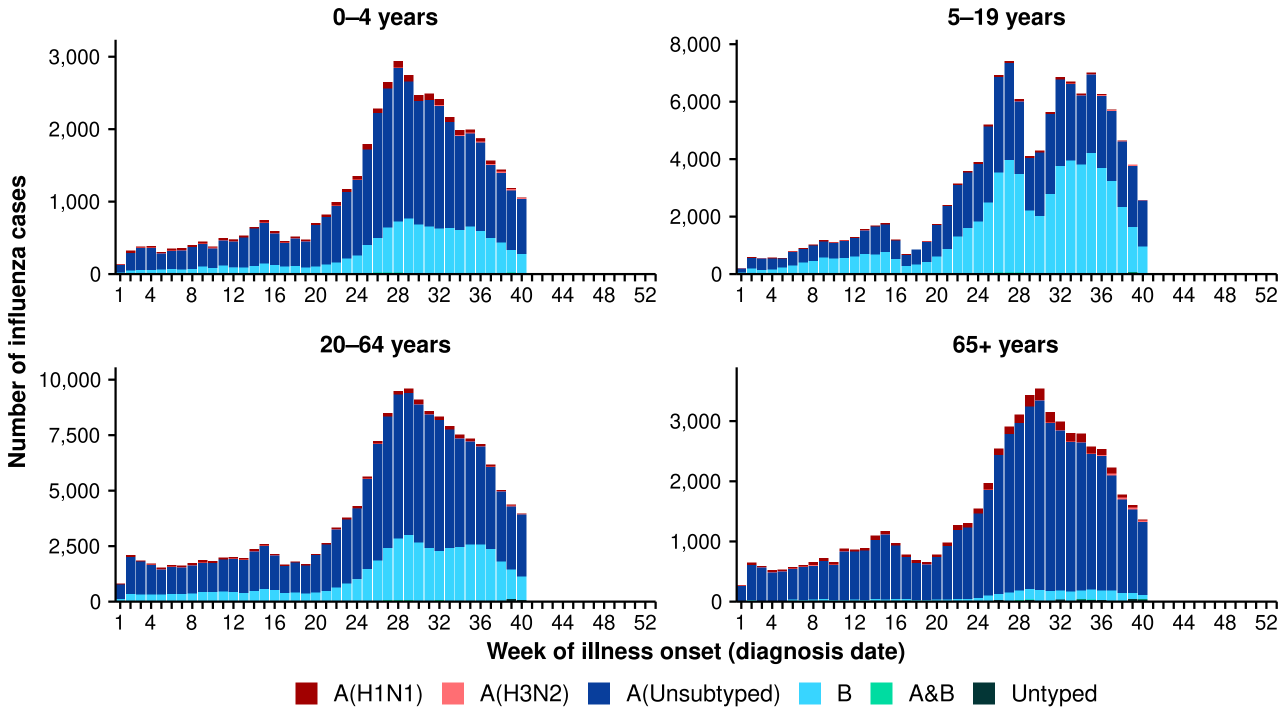
Figure 7: Notification rates* per 100,000 population for influenza cases by state or territory and week of diagnosis, Australia, 1 January to 5 October 2025



Source: National Notifiable Diseases Surveillance System (NNDSS)
* Rate per 100,000 population for the given time period. Population data are based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) for the reference period June 2024, released 12 December 2024.

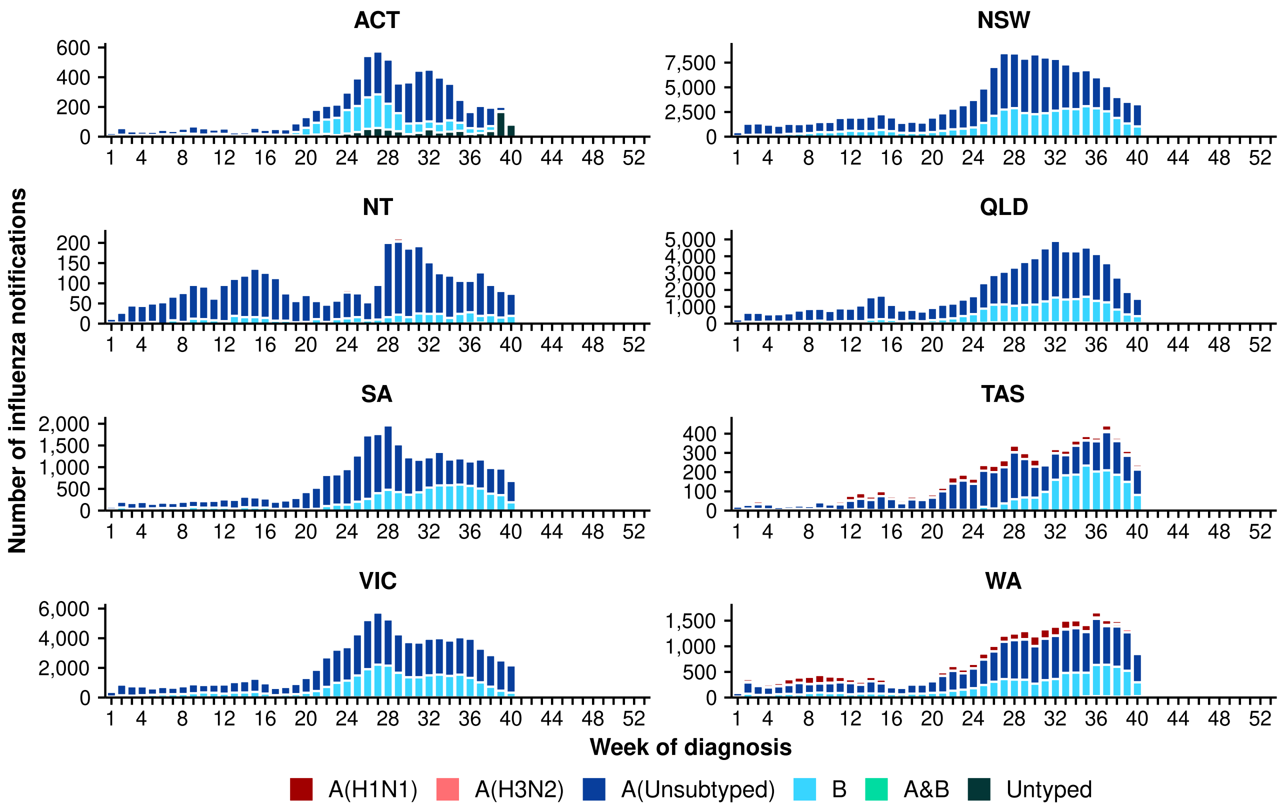
- In the last fortnight, most influenza notifications were influenza A(Unsubtyped) (68.0%; 13,555/19,937), followed by influenza B (28.2%; 5,627/19,937), then influenza untyped (1.8%; 365/19,937), influenza A(H3N2) (1.1%; 226/19,937) and influenza A(H1N1) (0.7%; 147/19,937). In the last fortnight, there were 17 influenza A&B co-detections (Figure 8).
- In the year to date, influenza A(Unsubtyped) has accounted for most cases across most age groups, followed by influenza B. The proportion of influenza B cases is the highest in the 5–19 years age group. There has been a small number of influenza A(H1N1) and influenza A(H3N2) cases across all age groups (Figure 8).
  - There is a comparatively higher proportion of influenza B cases this season than observed in 2024. While influenza B is often a good match with the seasonal influenza vaccine strain, influenza B can result in more severe infections in children (Figure 9).
- In the year to date, influenza A(Unsubtyped) has accounted for the majority of influenza cases across all jurisdictions. (Figure 9). All jurisdictions have experienced increasing numbers of influenza B cases in the year to date; however, the proportion of influenza B and influenza A varies week-on-week (Figure 9)
- In recent weeks, a slight increase in the number of influenza A(H3N2) has been subtyped in Tas and WA (Figure 9); however, trends in influenza subtypes should be interpreted with care as there are jurisdictional differences in the number and selection of influenza samples that undergo typing.

Figure 8: Notified influenza cases by influenza subtype, age group*, and week of diagnosis, Australia, 1 January to 5 October 2025



Source: National Notifiable Diseases Surveillance System (NNDSS)
* Axis varies between age groups.

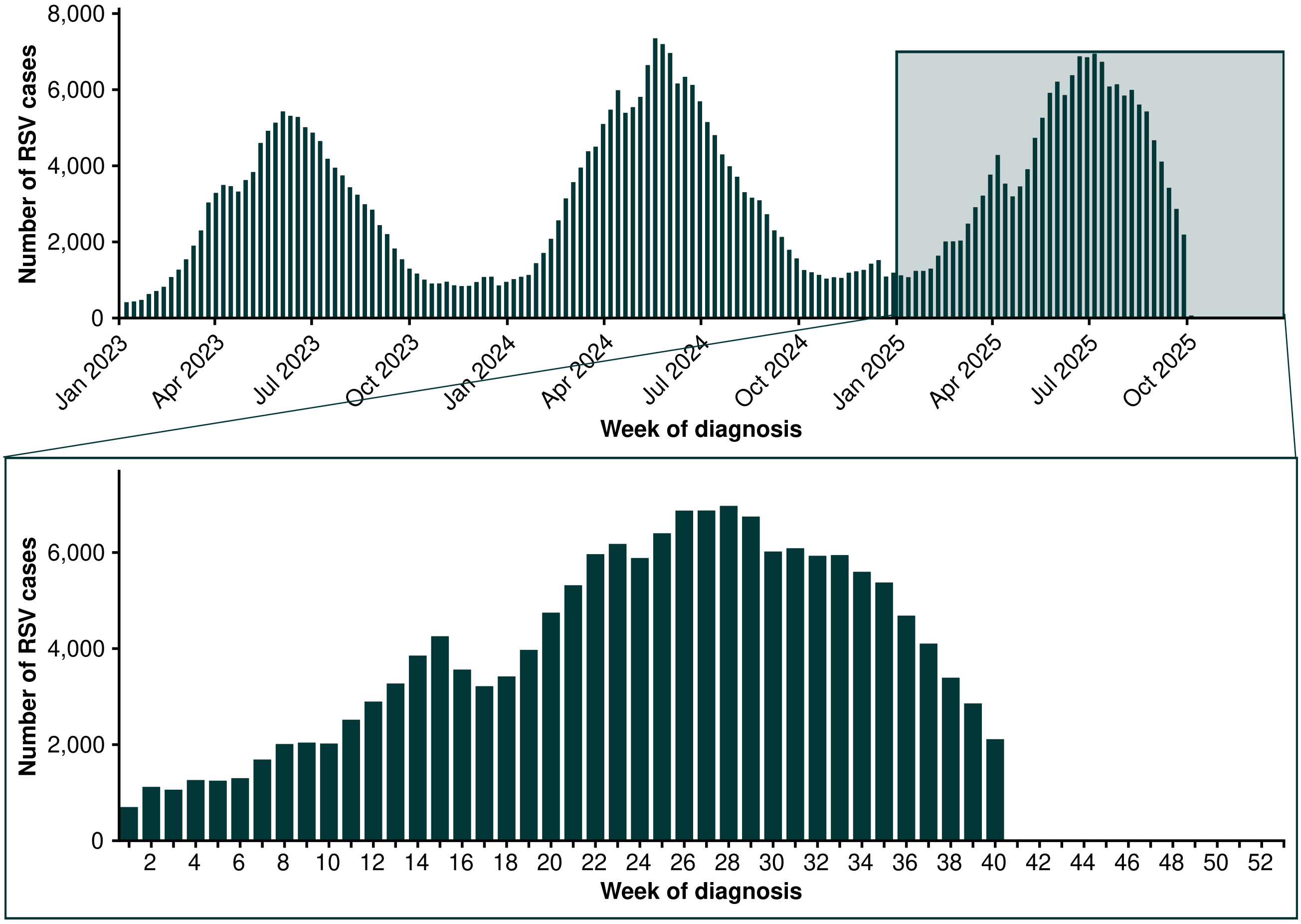
Figure 9: Notified influenza cases by influenza subtype, jurisdiction*, and week of diagnosis, Australia, 1 January to 5 October 2025



Source: National Notifiable Diseases Surveillance System (NNDSS)
* Axis varies between jurisdictions.

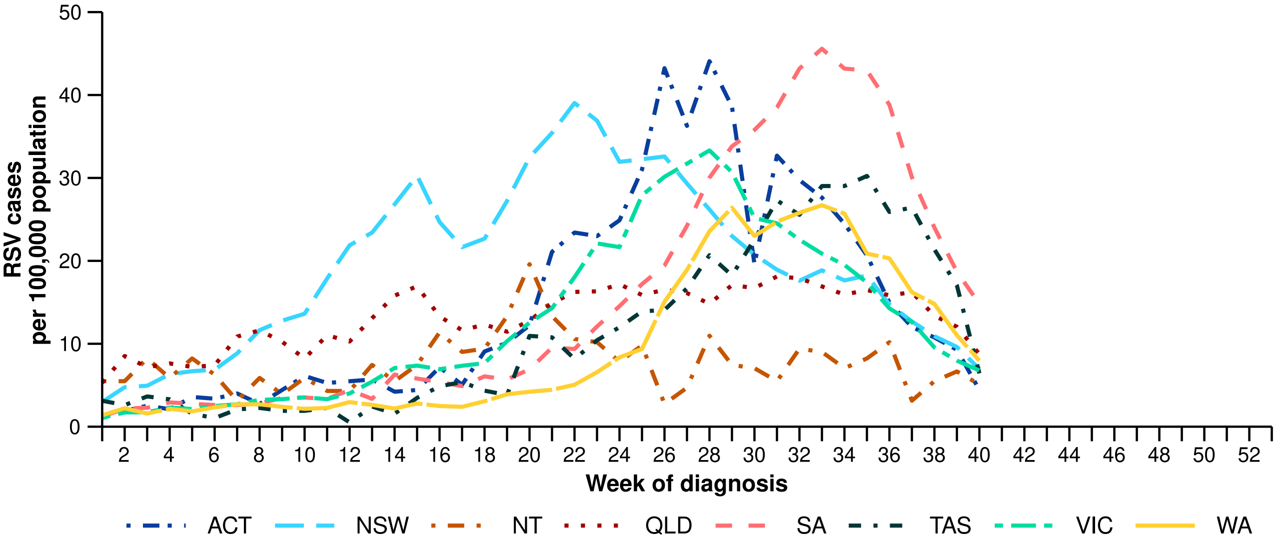
- In the last fortnight, the number of RSV cases decreased, continuing the decreasing trend in national case numbers observed since mid-July 2025 (Figure 10).
- The number of cases this year to date (n=160,488) is comparable with the number of cases observed in the same time period last year (n=160,488) (Figure 10).
- In the last fortnight, RSV notification rates decreased across all jurisdictions except for the NT, where the notification rate remained relatively stable compared with the previous fortnight (Figure 11).
- In the year to date, RSV notification rates remain considerably higher in children aged 0–4 years than in other age groups (Table 1).
- In the year to date, RSV notification rates are highest in NSW and lowest in the NT (Table 1).

Figure 10: Notified RSV cases by year and week of diagnosis*, Australia, 2023 to 5 October 2025



Source: National Notifiable Diseases Surveillance System (NNDSS)
* RSV became notifiable in all states and territories on 1 September 2022 and comprehensive national notification data became available after this point. For this reason, RSV notification trends are only presented from 1 January 2023.

Figure 11: Notification rates* per 100,000 population for RSV cases by state or territory and week of diagnosis, Australia, 1 January to 5 October 2025



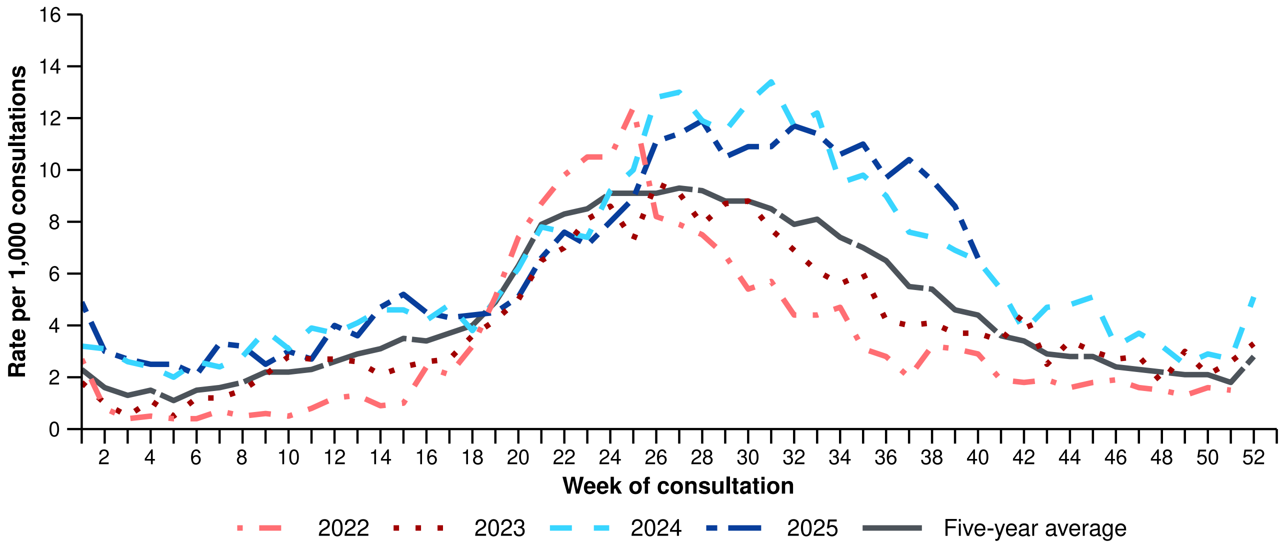
Source: National Notifiable Diseases Surveillance System (NNDSS)
* Rate per 100,000 population for the given time period. Population data are based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) for the reference period June 2024, released 12 December 2024.

Primary care surveillance

Primary care surveillance monitors the number and characteristics of people who have presented to a general practice with influenza-like illness and provides insight on the different respiratory pathogens that are causing illness in the community.

- In the last fortnight (22 September to 5 October 2025), there were fewer general practice consultations for influenza-like illness (7.6 notifications per 1,000 consultations per fortnight) compared to the previous fortnight (10.0 notifications per 1,000 consultations per fortnight) (Figure 12).
- From late June 2025, influenza-like illness consultation rates have been higher than in 2022, 2023 and the five-year average but have continued the similar downward trend observed at the same time in 2024 (Figure 12).

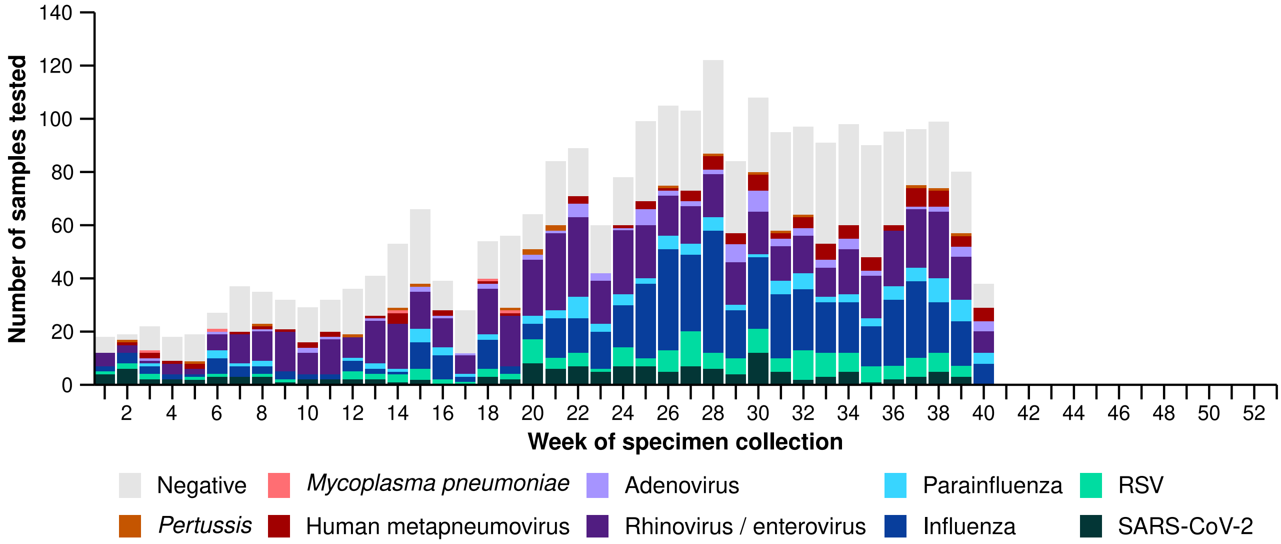
Figure 12: Rate of influenza-like illness notifications per 1,000 consultations per week in sentinel general practice sites compared with the five-year average by year and week of consultation*†, Australia, 2022 to 5 October 2025



Source: Australian Sentinel Practice Research Network (ASPREN)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2018 to 2019 and 2022 to 2024. Please refer to the Technical Supplement for interpretation of the five-year average.
† Please refer to the Technical Supplement for notes on impact of COVID-19 on ASPREN data.

- In the last fortnight, 72.9% (86/118) of people attending general practice with influenza-like illness who were tested have then tested positive for a respiratory pathogen.
- In the last fortnight, influenza (29.1%; 25/86) continued to be the most commonly detected pathogen, followed by rhinovirus (27.9%; 24/86) and parainfluenza type-3 (11.6%; 10/86) (Figure 13).
- In the year to date, 67.2% (1,705/2,536) of people attending general practice with influenza-like illness who were tested have then tested positive for a respiratory pathogen.
- In the year to date, rhinovirus (33.3%; 568/1,705) has been the most commonly detected pathogen, followed by influenza (30.6%; 522/1,705), RSV (9.4%; 161/1,705), SARS-CoV-2 (8.5%; 145/1,705), and human metapneumovirus (5.6%; 95/1,705) (Figure 13).

Figure 13: Number of samples tested for respiratory pathogens among people with influenza-like illness attending sentinel general practice sites by respiratory pathogen and week of specimen collection, Australia, 1 January to 5 October 2025



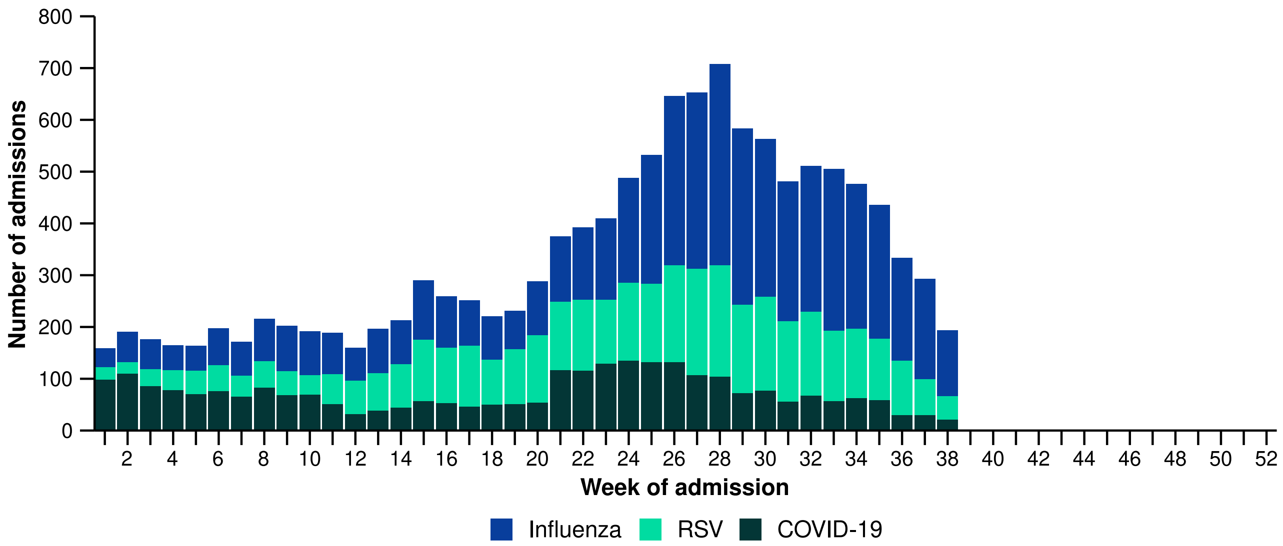
Source: Australian Sentinel Practice Research Network (ASPREN)
Note: All ASPREN swab samples are transported to the SA Pathology laboratory in Adelaide to be tested for viral and bacterial respiratory pathogens via a multiplex real-time reverse transcription polymerase chain reaction (RT-PCR) assay using in-house primers.

Hospital-based surveillance

Hospital-based surveillance monitors persons with more severe illness who have been admitted to hospital for their respiratory illness (severe acute respiratory infections). Hospital-based surveillance also measures the ability of the health system to cope with the number of severe acute respiratory infection admissions to ensure delivery of safe, timely and quality health care.

- In the last severity reporting period (8 September to 21 September 2025), fewer patients were admitted to a sentinel hospital with a severe acute respiratory infection (n=487), than in the previous severity reporting period (n=769).
  - In the last severity reporting period, at sentinel hospitals there was 42.7% fewer admissions with COVID-19 (from 89 to 51), 29.5% fewer admissions with influenza (from 457 to 322), and 48.9% fewer admissions with RSV (from 223 to 114), compared to the previous severity reporting period.
- In the year to date for severity reporting (1 January to 21 September 2025), there have been 12,707 admissions with severe acute respiratory infections at sentinel hospitals. Most patients with a severe acute respiratory infection have been admitted with influenza (n=6,017) followed by RSV (n=3,900) (Figure 14).

Figure 14: Total number of patients (children and adults) admitted with a severe acute respiratory infection to sentinel hospitals by disease and week of admission, Australia, 1 January to 21 September 2025

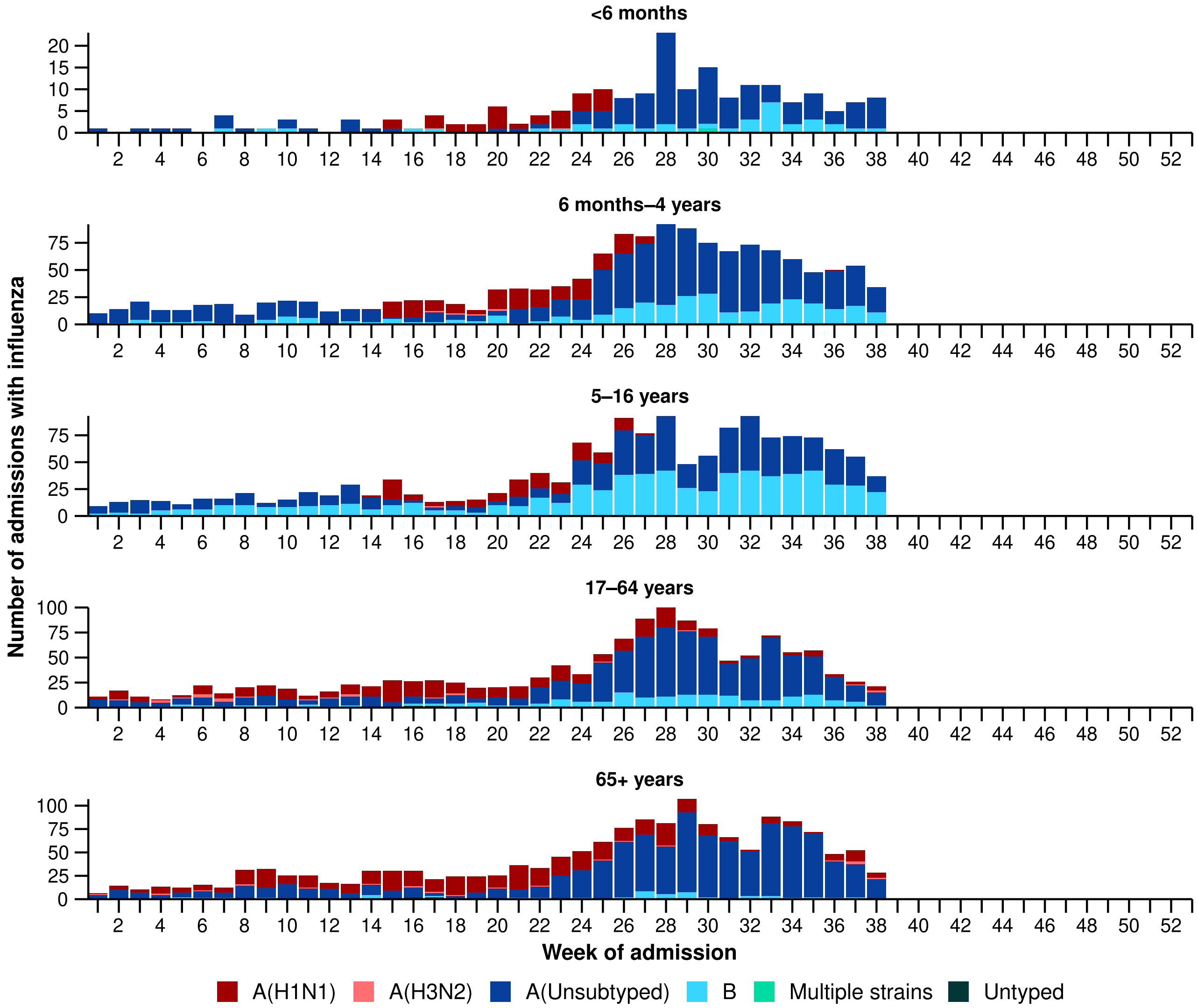


Source: Influenza Complications Alert Network (FluCAN)

- Patients admitted to sentinel hospitals with influenza have mostly been admitted with influenza A (78.7%; 4,738/6,017), while 20.9% (1,255/6,017) were admitted with influenza B.
  - Most hospital admissions with influenza A have been with influenza A(Unsubtyped) (75.4%; 3,574/4,738), followed by influenza A(H1N1) (23.4%; 1,111/4,738) and then influenza A(H3N2) (1.1%; 53/4,738).
- In the year to date for severity reporting, influenza A was the most commonly detected influenza type in all age groups. Influenza A(H1N1) and influenza A(H3N2) subtypes have been more commonly observed in adults than children, while influenza B has been more commonly observed in children. Of note, school aged children (5–16 years) had the highest proportion of influenza B compared with influenza A (Figure 15).
  - While influenza B is often a good match with the seasonal influenza vaccine strain, influenza B can result in more severe infections in children.

– Trends in influenza types/subtypes should be interpreted with care as there may be differences in the number and selection of influenza samples that undergo typing.

Figure 15: Number of patients admitted with influenza to sentinel hospitals by influenza subtype, age group*, and week of admission, Australia, 1 January to 21 September 2025



Source: Influenza Complications Alert Network (FluCAN)
* Axis varies between age groups. The age distribution of admissions with influenza may not reflect the age distribution of all patients.

- In the year to date for severity reporting, a similar number of children (those aged 16 years and younger) have been admitted to sentinel hospitals with RSV or influenza than with COVID-19 (Table 2a).
- Children admitted to sentinel hospitals with influenza tended to be older than children admitted with COVID-19 or RSV (Table 2a).
- Children admitted to sentinel hospitals with RSV had a slightly longer length of hospital stay compared to children with influenza or COVID-19; however, the difference in the length of stay was minor. The proportion of children admitted directly to intensive care was slightly higher for COVID-19 than influenza and RSV (Table 2a).
- Sadly, there have been a small number of children admitted with a severe acute respiratory infections who have died in sentinel hospitals (Table 2a).

Table 2a: Demographic characteristics and outcomes for children admitted with a severe acute respiratory infection to a sentinel hospital by disease*†‡, Australia, 1 January to 21 September 2025

	COVID-19 Year to date for severity reporting (n=855)	Influenza Year to date for severity reporting (n=3,120)	RSV Year to date for severity reporting (n=3,169)
Age (years)			
Median [IQR]	1 [0–4]	4 [1–8]	1 [0–2]
Age group (years)			
< 6 months	265 (31.0%)	197 (6.3%)	753 (23.8%)
6 months – 4 years	383 (44.8%)	1429 (45.8%)	2164 (68.3%)
5–16 years	207 (24.2%)	1494 (47.9%)	252 (8.0%)
Indigenous status			
Aboriginal and Torres Strait Islander	78 (9.1%)	211 (6.8%)	195 (6.2%)
Length of hospital stay (days)†			
Median [IQR]	1 [1–3]	1 [1–2]	2 [1–3]
Patient admission location‡			
Admitted to hospital ward	792 (92.6%)	2955 (94.7%)	2996 (94.5%)
Admitted to intensive care directly	63 (7.4%)	165 (5.3%)	173 (5.5%)
Discharge status†			
Alive	641 (75.0%)	2332 (74.7%)	2386 (75.3%)
Died	1 (0.1%)	5 (0.2%)	1 (0.0%)
Incomplete/missing	213 (24.9%)	783 (25.1%)	782 (24.7%)

Source: Influenza Complications Alert Network (FluCAN)
* Does not include patients with missing age; therefore, the sum of age-specific totals above may not equal the total number of patients.
† For patients who are still in hospital data may not be complete; therefore, these data are not included in the length of stay or discharge status. In addition, length of stay data excludes patients that acquired their infection in hospital.
‡ Admission location reflects the initial admission ward. Some patients may be initially admitted to general ward then later admitted to an intensive care and this is not reflected here. Does not include patients with missing admission location; therefore, the sum of admission location specific totals above may not equal the total number of patients.

The Paediatric Active Enhanced Disease Surveillance (PAEDS) network carries out enhanced sentinel hospital surveillance for some acute respiratory infections or conditions in children. PAEDS data for acute respiratory infections in children are presented in the Australian Respiratory Surveillance Reports in the sentinel hospital data from FluCAN. For additional information on COVID-19 in children, Paediatric Inflammatory Multisystem Syndrome (PIMS-TS) following COVID-19, influenza in children, or RSV in children please visit the PAEDS webpages and dashboards.

- In the year to date for severity reporting, more adults (those aged 17 years and over) have been admitted to sentinel hospitals with influenza than with COVID-19 or RSV (Table 2b).
- Adults admitted to sentinel hospitals with COVID-19 or RSV were predominately 65 years and over, whereas the proportion of admissions with influenza was only slightly higher in the 65 years and over age group compared to the 17–64 years age group (Table 2b).
- Adults admitted to sentinel hospitals with COVID-19 had a slightly longer length of hospital stay compared to adults with influenza or RSV; however, the difference in the length of stay was minor. A higher proportion of adults with influenza were admitted directly to intensive care, compared to adults admitted with COVID-19 or RSV (Table 2b).
- Sadly, there have been a number of adults admitted with a severe acute respiratory infections who have died in sentinel hospitals (Table 2b).

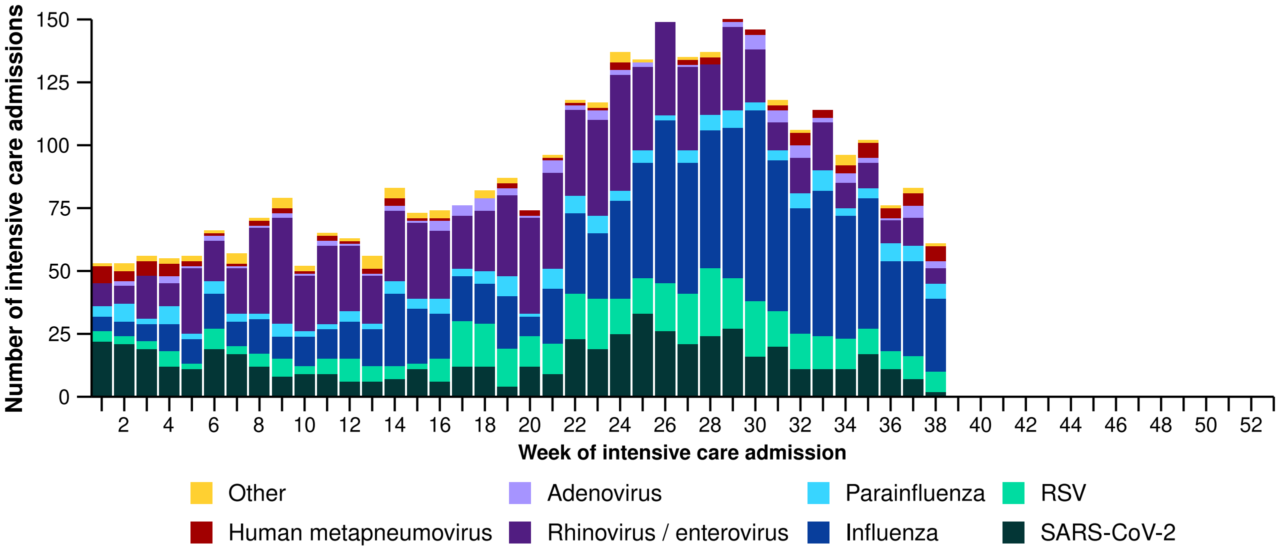
Table 2b: Demographic characteristics and outcomes for adults admitted with a severe acute respiratory infection to a sentinel hospital by disease*†‡, Australia, 1 January to 21 September 2025

	COVID-19 Year to date for severity reporting (n=1,935)	Influenza Year to date for severity reporting (n=2,896)	RSV Year to date for severity reporting (n=731)
Age (years)			
Median [IQR]	75 [62–84]	66 [52–77]	74 [61–83]
Age group (years)			
17–64 years	553 (28.6%)	1339 (46.2%)	219 (30.0%)
65 years and over	1382 (71.4%)	1557 (53.8%)	512 (70.0%)
Indigenous status			
Aboriginal and Torres Strait Islander	108 (5.6%)	254 (8.8%)	44 (6.0%)
Length of hospital stay (days)†			
Median [IQR]	5 [3–10]	4 [2–7]	4 [2–8]
Patient admission location‡			
Admitted to hospital ward	1828 (94.5%)	2679 (92.5%)	688 (94.1%)
Admitted to intensive care directly	107 (5.5%)	217 (7.5%)	43 (5.9%)
Discharge status†			
Alive	1491 (77.1%)	2083 (71.9%)	486 (66.5%)
Died	73 (3.8%)	87 (3.0%)	26 (3.6%)
Incomplete/missing	371 (19.2%)	726 (25.1%)	219 (30.0%)

Source: Influenza Complications Alert Network (FluCAN)
* Does not include patients with missing age; therefore, the sum of age-specific totals above may not equal the total number of patients.
† For patients who are still in hospital data may not be complete; therefore, these data are not included in the length of stay or discharge status. In addition, length of stay data excludes patients that acquired their infection in hospital.
‡ Admission location reflects the initial admission ward. Some patients may be initially admitted to general ward then later admitted to an intensive care and this is not reflected here. Does not include patients with missing admission location; therefore, the sum of admission location specific totals above may not equal the total number of patients.

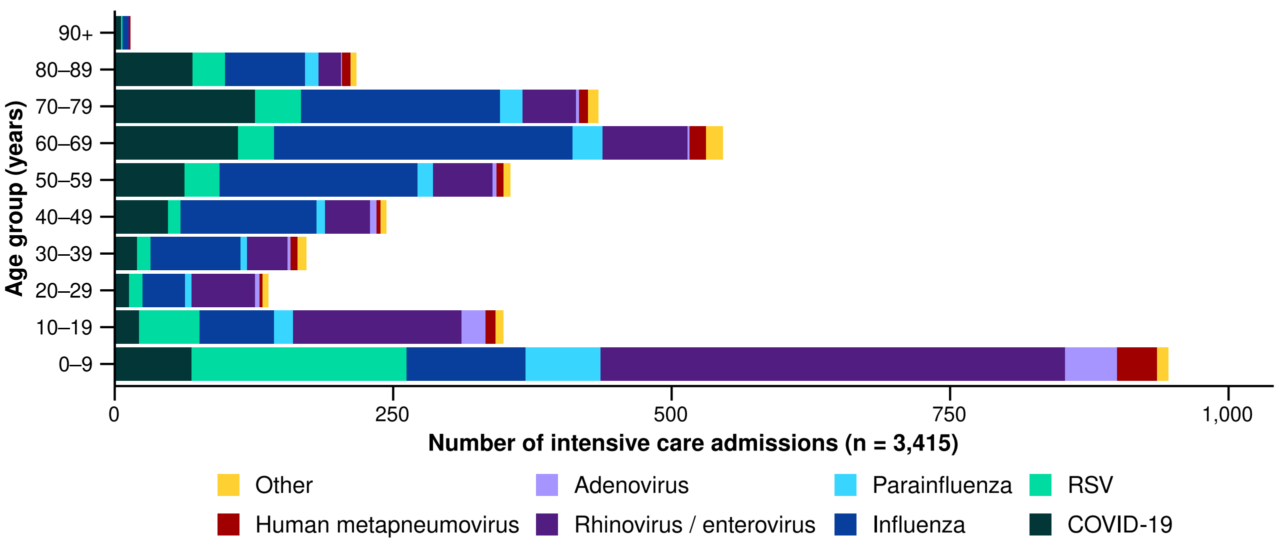
- In the last severity reporting period for sentinel intensive care (25 August to 21 September 2025), fewer patients have been admitted to a sentinel intensive care with a severe acute respiratory infection (n=310), than in the previous severity reporting period (n=407) (Figure 16).
- In the year to date for severity reporting (1 January to 21 September 2025), most patients were admitted to sentinel intensive care with influenza, followed by rhinovirus / enterovirus (Figure 16; Table 3).

Figure 16: Number of patients admitted with severe acute respiratory infections to a sentinel intensive care by disease and week of admission, Australia, 1 January to 21 September 2025



Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: A range of diagnostic testing procedures are utilised across hospitals in Australia. SPRINT-SARI does not specify which diagnostic testing method should be utilised as this is the domain of the hospital and treating clinicians. Therefore, virological data from SPRINT-SARI should be interpreted with care.

Figure 17: Number of patients admitted with severe acute respiratory infections to a sentinel intensive care by disease and age group*, Australia, 1 January to 21 September 2025



Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: 5.3% (172/3,232) of patients had co-infections of respiratory pathogens; therefore, the sum of pathogen-specific totals above may not equal the total number of severe acute respiratory infection patients.
* The age distribution of severe acute respiratory infection intensive care admissions may not reflect the age distribution of all patients.

- In the year to date for severity reporting, admissions to a sentinel intensive care with COVID-19 or influenza have generally been among older people. In contrast, admissions with Human metapneumovirus, rhinovirus / enterovirus or RSV have been among younger people, primarily those aged 0–9 years old (Figure 17; Table 3).
- A higher proportion of admissions with influenza and parainfluenza required invasive mechanical ventilation and the length of ventilation was longest among those with influenza. The length of intensive care stay was relatively similar across diseases (Table 3).
- Most patients admitted to a sentinel intensive care with a severe acute respiratory infection have been discharged home. Sadly, a number of patients have died in hospital, predominately among those with COVID-19 (Table 3).

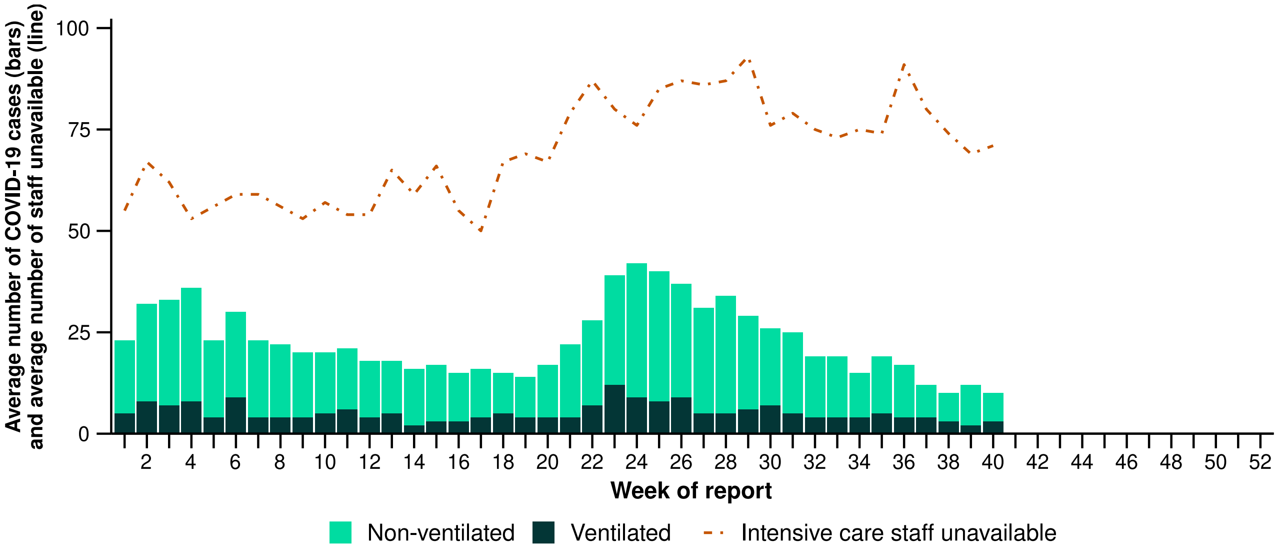
Table 3: Demographic characteristics and outcomes of patients admitted with a severe acute respiratory infection to a sentinel intensive care by disease*†, Australia, 1 January to 21 September 2025

	COVID-19 Year to date for severity reporting (n=548)	hMPV Year to date for severity reporting (n=96)	Influenza Year to date for severity reporting (n=1,118)	Parainfluenza Year to date for severity reporting (n=177)	Rhinovirus Year to date for severity reporting (n=899)	RSV Year to date for severity reporting (n=416)	Other Year to date for severity reporting (n=162)
Age (years)							
Median [IQR]	64 [42–75]	28 [4–66]	58 [37–69]	26 [6–66]	11 [4–43]	11 [2–59]	18 [6–55]
Indigenous status							
Aboriginal and Torres Strait Islander	48 (8.8%)	5 (5.2%)	87 (7.8%)	11 (6.2%)	84 (9.3%)	32 (7.7%)	18 (11.1%)
Non-Indigenous	500 (91.2%)	91 (94.8%)	1031 (92.2%)	166 (93.8%)	815 (90.7%)	384 (92.3%)	144 (88.9%)
Received invasive mechanical ventilation							
Number (%)	153 (27.9%)	26 (27.1%)	382 (34.2%)	68 (38.4%)	254 (28.3%)	85 (20.4%)	63 (38.9%)
Length of invasive mechanical ventilation (days)*							
Median [IQR]	3 [1–6]	4 [2–8]	5 [2–11]	3 [1–9]	3 [1–7]	3 [1–7]	3 [1–7]
Length of intensive care stay (days)*							
Median [IQR]	3 [2–5]	4 [2–6]	3 [2–7]	3 [1–7]	2 [1–5]	3 [2–5]	3 [2–6]
Length of hospital stay (days)*							
Median [IQR]	8 [4–15]	8 [5–13]	8 [4–16]	6 [3–14]	6 [3–12]	5 [3–10]	7 [3–17]
Patient outcome†							
Ongoing care in intensive care	12 (2.2%)	3 (3.1%)	38 (3.4%)	4 (2.3%)	11 (1.2%)	3 (0.7%)	–
Ongoing care in hospital ward	14 (2.6%)	3 (3.1%)	22 (2.0%)	9 (5.1%)	17 (1.9%)	9 (2.2%)	8 (4.9%)
Transfer to other hospital / facility	92 (16.8%)	12 (12.5%)	175 (15.7%)	24 (13.6%)	89 (9.9%)	46 (11.1%)	20 (12.3%)
Discharged home	335 (61.1%)	67 (69.8%)	755 (67.5%)	129 (72.9%)	723 (80.4%)	332 (79.8%)	117 (72.2%)
Died in hospital	90 (16.4%)	11 (11.5%)	123 (11.0%)	10 (5.6%)	54 (6.0%)	26 (6.2%)	16 (9.9%)

Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: 5.3% (172/3,232) of patients had co-infections of respiratory pathogens; therefore, the sum of pathogen-specific totals above may not equal the total number of severe acute respiratory infection patients.
* For patients receiving ongoing care in intensive care data may not be complete; therefore, data are not included in the length of ventilation or stay.
† Patients who have been admitted with no discharge information for less than 90 days have been assumed to have ongoing care in the hospital. Patients who have no outcome entered or have been admitted for more than 90 days with no discharge information have been treated as missing.

- In the last fortnight (22 September to 5 October 2025), there were a similar average number of COVID-19 cases occupying intensive care beds across Australia than in the previous fortnight (Figure 18).
- In the last fortnight, there were less intensive care staff unavailable to work due to illness across Australia than in the previous fortnight (Figure 18).

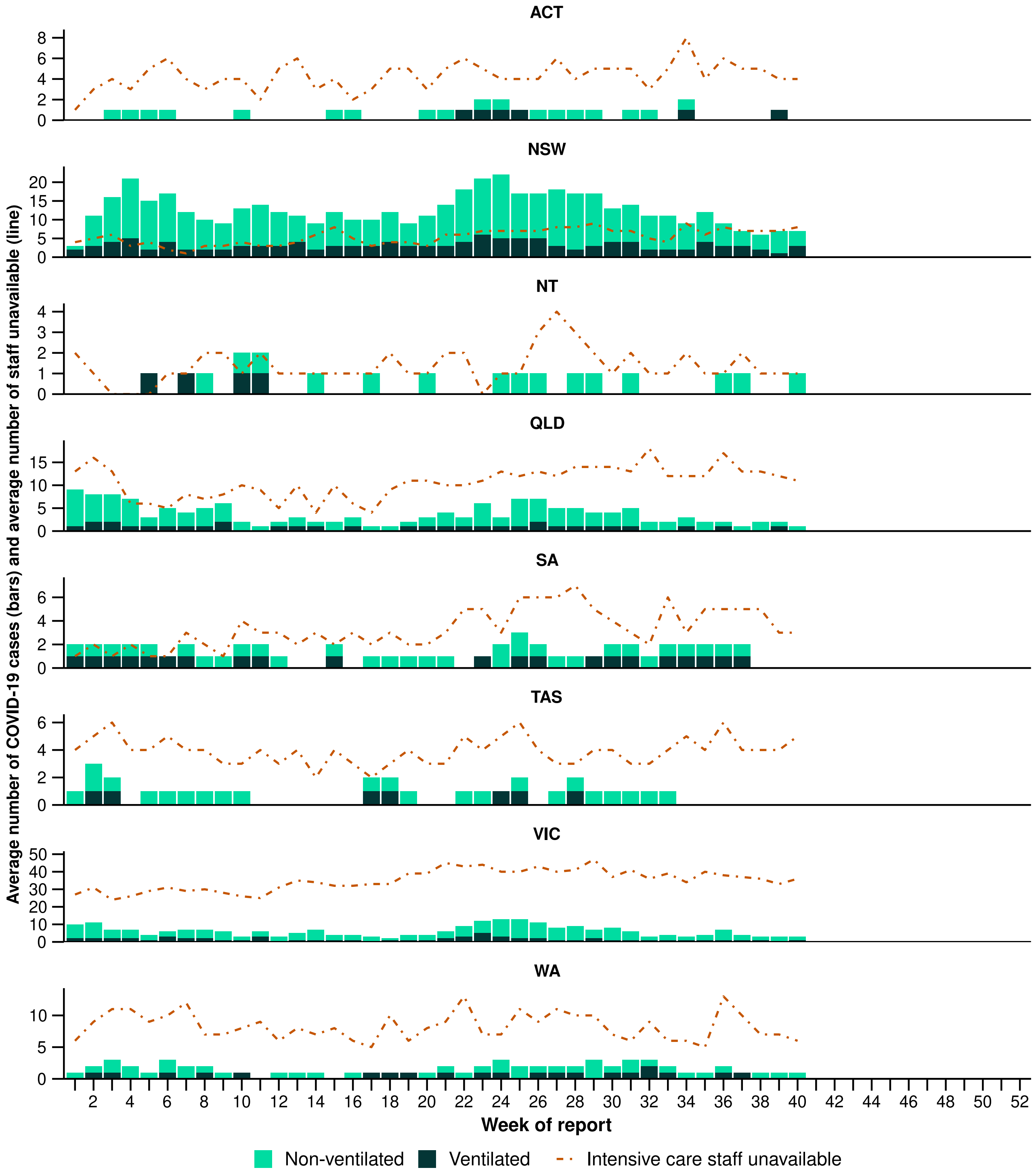
Figure 18: Average number of COVID-19 cases in intensive care and the average number of intensive care staff unavailable to work due to illness by week of report*†, Australia, 1 January to 5 October 2025



Source: Critical Health Resource Information System (CHRIS)
* Average number of ventilated and non-ventilated COVID-19 cases in intensive care includes only active COVID-19 cases (those in isolation) and does not include cleared COVID-19 cases.
† Intensive care staff include both medical and nursing staff. Staff unavailability will be underestimated in NSW as most public hospitals in NSW do not report staff unavailability.

- In the last fortnight, the number of COVID-19 cases occupying intensive care beds increased slightly in NSW, and remained stable in Tas, Vic, the NT, Qld, SA, the ACT, and WA compared with the previous fortnight (Figure 19).
- In the last fortnight, the number of intensive care staff unavailable to work due to illness increased in NSW, Tas and Vic, decreased in Qld and WA and remained stable in the ACT, the NT and SA compared with the previous fortnight (Figure 19).

Figure 19: Average number of COVID-19 cases in intensive care and the average number of intensive care staff unavailable to work due to illness by jurisdiction and week of report*†‡, Australia, 1 January to 5 October 2025



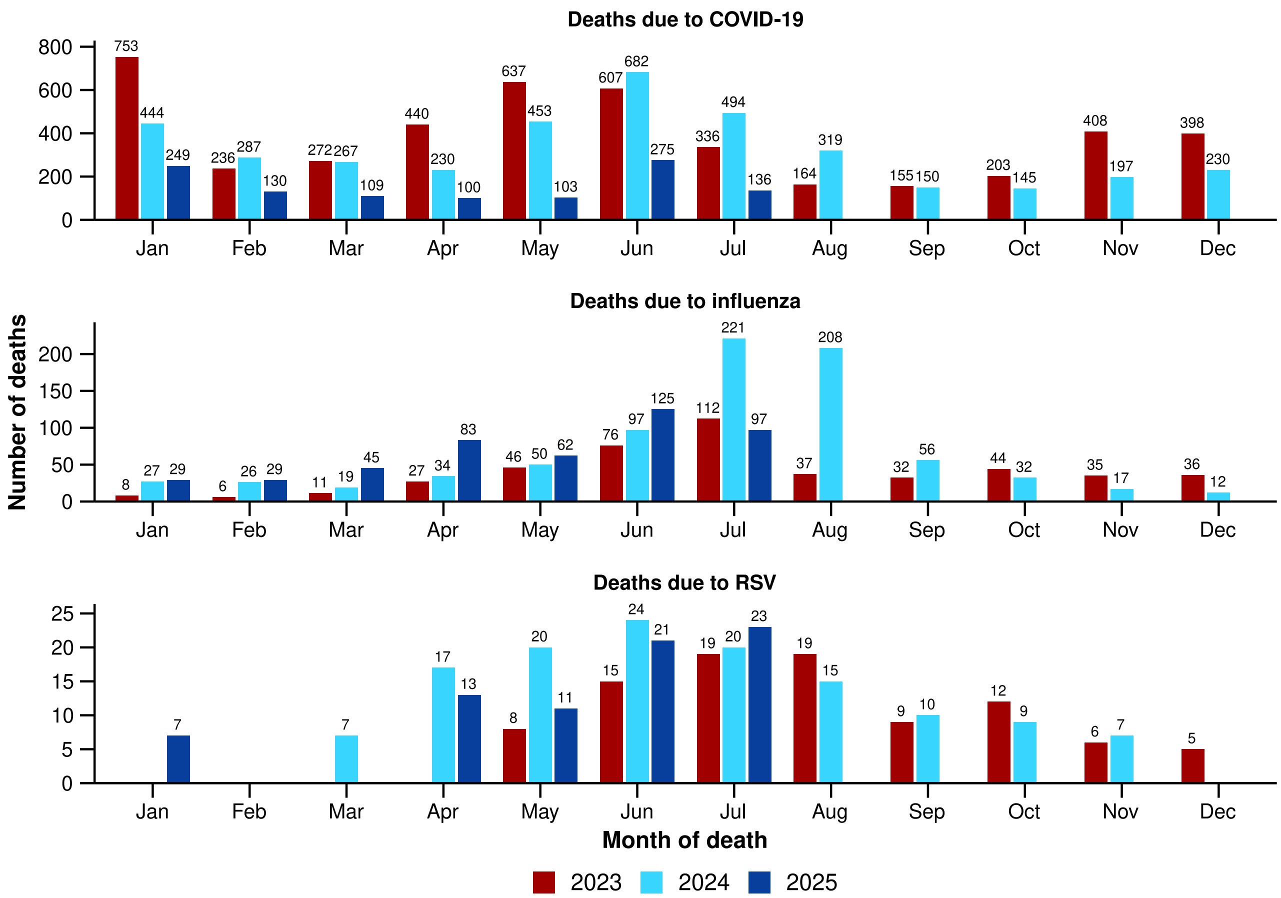
Source: Critical Health Resource Information System (CHRIS)
* Axis varies between jurisdictions.
† Average number of ventilated and non-ventilated COVID-19 cases in intensive care includes only active COVID-19 cases (those in isolation) and does not include cleared COVID-19 cases.
‡ Intensive care staff include both medical and nursing staff. Staff unavailability will be underestimated in NSW as most public hospitals in NSW do not report staff unavailability.

Mortality surveillance

Death registrations can provide information on the scale and severity of disease associated with acute respiratory infections. For more information on death registrations including completeness, timeliness, and definitions of deaths involving (both *due to* and *with*), *due to* and *with* acute respiratory infections, refer to the Technical Supplement.

- *Please note, there has not been an update to the Provisional Mortality Statistics, as such the mortality surveillance data presented here have not been updated since the previous report.*
- An acute respiratory associated death is one where the death was directly caused by, or due to, the disease (the virus has caused terminal complications such as pneumonia) or the person has died with the disease (a person has died from another cause but the illness still contributed significantly to death).
- COVID-19 has been the leading cause of acute respiratory infection mortality across 2023–2025.
- Since the end of 2021, a pattern has been observed for COVID-19 where there are two peaks of mortality during the year - one occurring between November and January and the other occurring between May and August. While there was still an increase in deaths involving COVID-19 occurring between November 2024 and January 2025, the number of deaths occurring during this period was much lower than other years (Figure 20a/b).
- The number of deaths *due to* (directly caused by) COVID-19 increased in June 2025 following the relatively low number of deaths *due to* COVID-19 each month between February and May. Deaths remain at lower levels than the same period in 2024 and 2023 (Figure 20a).

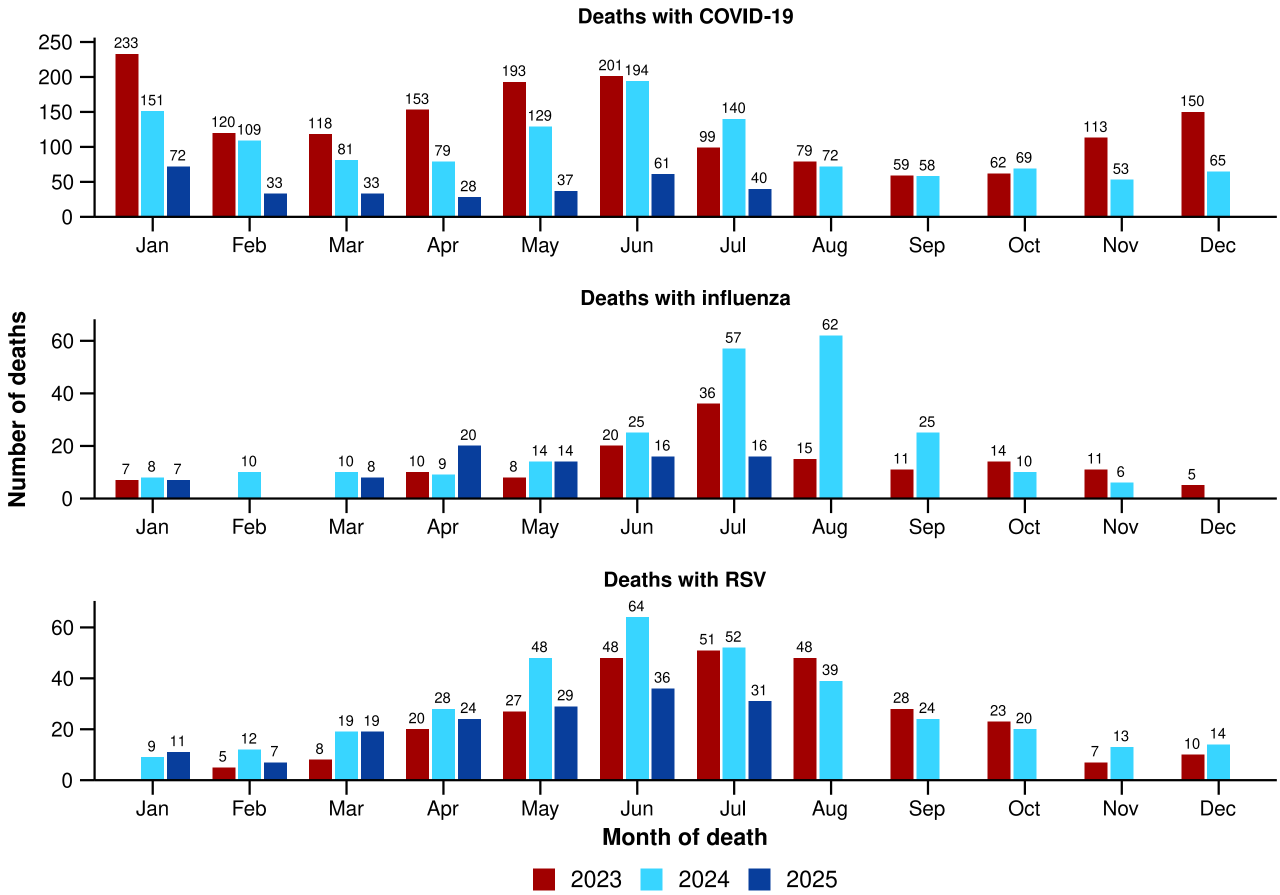
Figure 20a: Provisional numbers of deaths *due to* an acute respiratory infection*† by month, year, and disease, Australia, 1 January 2023 to 31 July 2025



Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia, released 29 August 2025.
* Axis varies between acute respiratory infections.
† Data is provisional and subject to change. It can take several weeks for death registrations to be reported, processed, coded, validated, and tabulated. Therefore, the data shown here may be incomplete. Data for some months were not published by the ABS due to small counts, and therefore not reported here. Data includes all deaths (both doctor and coroner certified) that occurred and were registered by 31 July 2025.

- Deaths *due to* influenza increased in June 2025 and the number of deaths that occurred in July is likely to increase further (Figure 20a).
- There were 373 deaths *due to* influenza in the first six months of 2025 (Figure 20a). Although higher than the number of deaths *due to* influenza in the same period in 2023 (174) or 2024 (253), it remains lower than the 436 deaths recorded in the first six months of 2019, which was a recent high mortality year for influenza.
- There were 81 deaths *due to* RSV in the first six months of 2025; however, for privacy reasons six deaths *due to* RSV are not published in Figure 20a.
- The mortality rate for deaths *due to* COVID-19 or influenza for Aboriginal and Torres Strait Islander people was higher than for non-Indigenous people across each year in 2022–2024.
- Deaths *with* (died from another cause but the illness still contributed significantly to death) COVID-19 increased in June 2025 but remained lower than in 2023 or 2024 (Figure 20b).
- Deaths *with* influenza in May and June 2025 remained below the number recorded in April 2025 (Figure 20b).
- Deaths *with* RSV have increased each month from February to June 2025, similar to the increasing trend during the same period in 2023 and 2024 (Figure 20b).
- All three of these acute respiratory infections are more likely to cause death in older age groups than younger age groups.

Figure 20b: Provisional numbers of deaths *with* an acute respiratory infection*† by month, year, and disease, Australia, 1 January 2023 to 31 July 2025



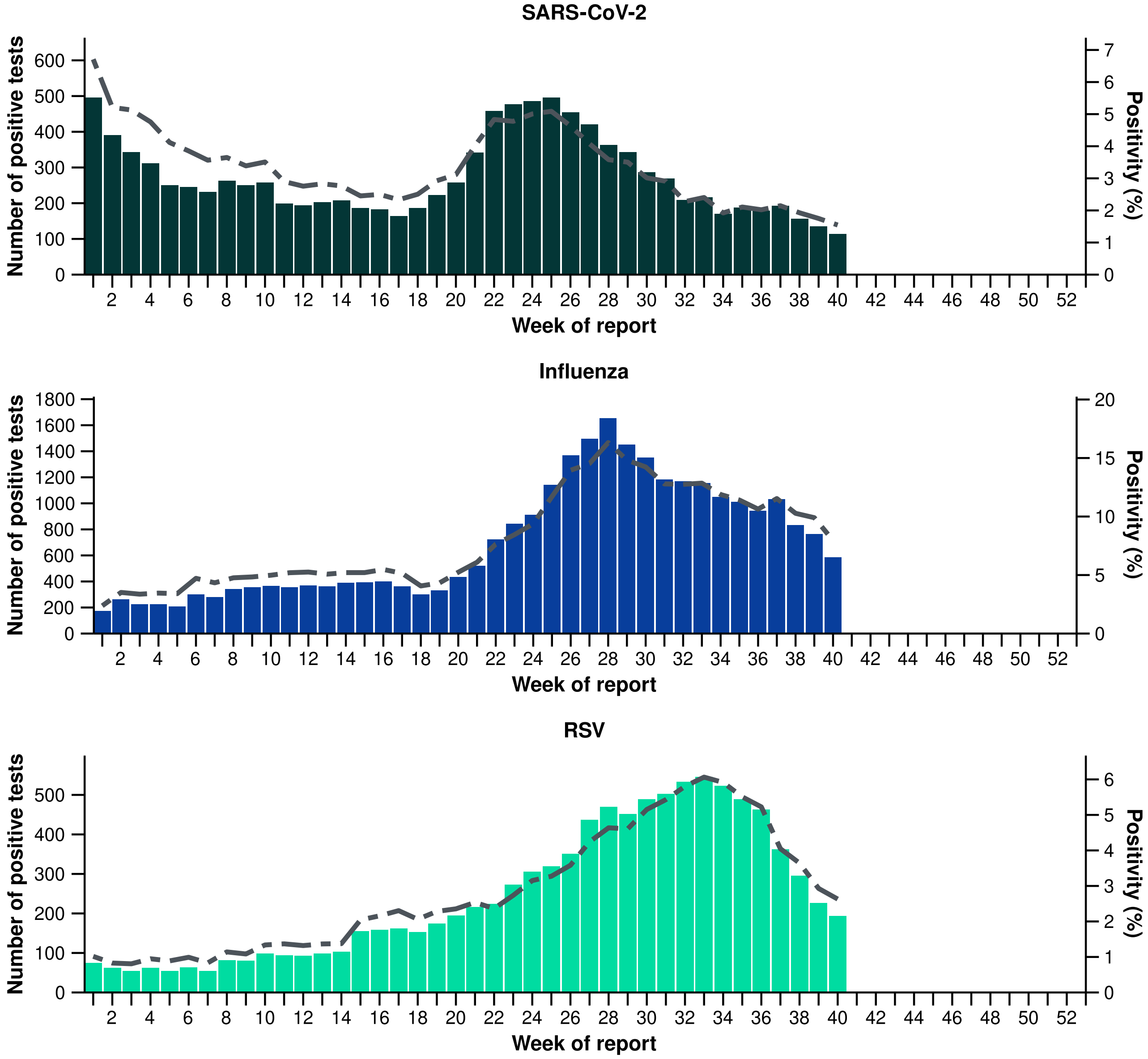
Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia, released 29 August 2025.
* Axis varies between acute respiratory infections.
† Data is provisional and subject to change. It can take several weeks for death registrations to be reported, processed, coded, validated, and tabulated. Therefore, the data shown here may be incomplete. Data for some months were not published by the ABS due to small counts, and therefore not reported here. Data includes all deaths (both doctor and coroner certified) that occurred and were registered by 31 July 2025.

Laboratory surveillance

Sentinel laboratory surveillance monitors and characterises respiratory pathogens to provide information on what pathogens are circulating, potential changes in the pathogens that might affect their infectiousness, severity, ability to evade vaccine and/or infection-acquired immunity, or resistance to antivirals.

- In the last fortnight (22 September to 5 October 2025), SARS-CoV-2 test positivity decreased slightly to 1.7% (211/12,361), influenza test positivity decreased slightly to 9.0% (1,351/15,093), and RSV test positivity decreased slightly to 2.7% (335/12,361) (Figure 21).

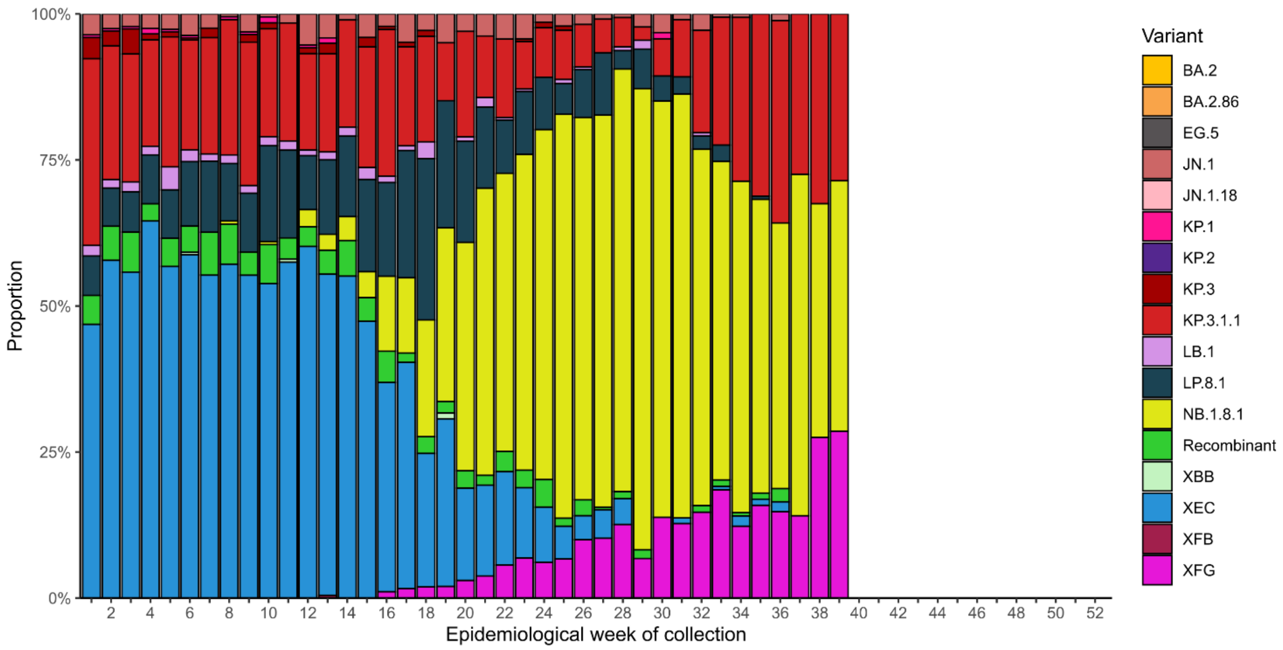
Figure 21: Number of tests positive (bars) and test positivity (line) for SARS-CoV-2, influenza or RSV of those specimens tested by sentinel laboratories by week of report*†, Australia, 1 January to 5 October 2025



Source: Sentinel laboratories, including National Influenza Centres
* Number of specimens tested excludes data from WA as testing denominator data are different for the three pathogens in Western Australia.
† A small minority of total samples from Victoria are tested only by respiratory panel (influenza, parainfluenza, adenovirus, human metapneumovirus, seasonal coronaviruses, RSV, and some picornaviruses) but not for SARS-CoV-2. These minority samples include only forensic materials; all other samples are tested by respiratory panel and SARS-CoV-2 assay.

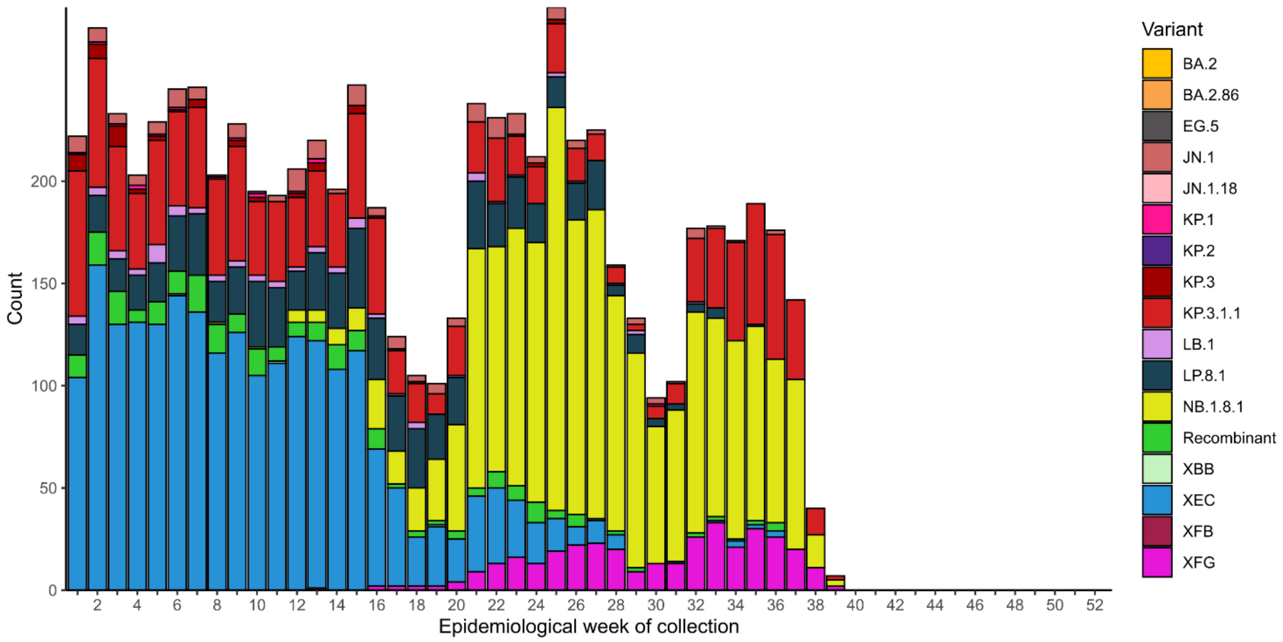
- There were 195 SARS-CoV-2 sequences uploaded to AusTrakka with dates of collection in the last 28 days (8 September to 5 October 2025). These sequences were from NSW, Qld, SA and WA, with the most recent collection date 23 September 2025.
- Most sequences were assigned to the BA.2.86 sub-lineage within B.1.1.529 (Omicron), or recombinants consisting of one or more Omicron sub-lineages (Figure 22a/b). In the last 28 days:
  - 27.7% (54/195) of sequences were from the sub-sub-lineages JN.1 (BA.2.86.1.1), including KP.3 (54/195). No sequences were identified from KP.2.
  - 69.2% (135/195) of sequences were recombinant or recombinant sub-lineages, including NB.1.8.1 and XFG.
  - 3.1% (6/195) of sequences were identified as BA.3.
  - There were no BA.1, BA.4, BA.5 or other BA.2 sub-sub-lineage sequences.
- NB.1.8.1 is the dominant sub-lineage in the last 28 days, accounting for 52.3% (102/195) of sequences (Figure 22a).
- The World Health Organization (WHO) have identified certain sub-sub-lineages and recombinants as variants under monitoring (VUM) or variants of interest (VOI) because of their epidemiological, pathological, or immunological features of concern. A select number are highlighted below due to their relevance in the Australian context. There are:
  - 351 XFG sequences in AusTrakka, with 33 collected in the last 28 days
  - 2,088 NB.1.8.1 sequences in AusTrakka, with 102 collected in the last 28 days
  - 765 LP.8.1 sequences in AusTrakka, with none collected in the last 28 days
  - 3,385 KP.3.1.1 sequences in AusTrakka, with 54 sequences collected in the last 28 days
  - 3,474 XEC sequences in AusTrakka, with none collected in last 28 days.

Figure 22a: SARS-CoV-2 Omicron sub-lineage* sequences by sample collection date, showing the proportions of sequences per week†‡, Australia, 1 January to 5 October 2025



Source: AusTrakka
* Some sub-sublineages are shown alongside their parent lineage, but not included in the parent lineage totals. For instance, KP.2 and KP.3 are sub-sub lineages of JN.1, so the total of JN.1 sequences will be higher than shown in the corresponding colour alone, and should include the KP.2 and KP.3 totals.
† Sequences in AusTrakka aggregated by week and reported based on date of sample collection, not date of sequencing.
‡ Proportions in Figure 22a may not be representative when sequence numbers are small; refer to Figure 22b. Data for earlier weeks may change between reporting periods as sequences with older collection dates are uploaded. These numbers are not equivalent to number of cases, as there are many cases which may not be sequenced. Non-VOI and non-VUM Omicron sub-lineages have been collapsed into parent lineages BA.1, BA.2, BA.3, BA.4 and BA.5.

Figure 22b: SARS-CoV-2 Omicron sub-lineage* sequences by sample collection date, showing the count of sequences per week†‡, Australia, 1 January to 5 October 2025



Source: AusTrakka
* Some sub-sublineages are shown alongside their parent lineage, but not included in the parent lineage totals. For instance, KP.2 and KP.3 are sub-sub lineages of JN.1, so the total of JN.1 sequences will be higher than shown in the corresponding colour alone, and should include the KP.2 and KP.3 totals.
† Sequences in AusTrakka aggregated by week and reported based on date of sample collection, not date of sequencing.
‡ Data for earlier weeks may change between reporting periods as sequences with older collection dates are uploaded. These numbers are not equivalent to number of cases, as there are many cases which may not be sequenced. Non-VOI and non-VUM Omicron sub-lineages have been collapsed into parent lineages BA.1, BA.2, BA.3, BA.4 and BA.5.

- In the year to date, the WHO Collaborating Centre for Reference and Research on Influenza has antigenically characterised 3,873 influenza viruses from Australia (Table 4), of which:
  - 73.2% (2,834/3,873) have been influenza A(H1N1)
  - 8.6% (334/3,873) have been influenza A(H3N2)
  - 18.2% (705/3,873) have been influenza B/Victoria.
- In the year to date, there have been no influenza B/Yamagata viruses characterised (Table 4). The last influenza B/Yamagata virus characterised in Australia was in a sample from 2020.
- Of the influenza A(H1N1) samples tested for neuraminidase inhibitor resistance, 2.2% (28/1,289) demonstrated highly reduced inhibition to Oseltamivir. None of the influenza A(H3N2) samples tested for neuraminidase inhibitor resistance demonstrated highly reduced inhibition to Oseltamivir.
- None of the samples tested demonstrated highly reduced inhibition to Zanamivir.

Table 4: Australian influenza viruses typed by haemagglutination inhibition assay and jurisdiction*†, 1 January to 5 October 2025

Strain	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
A(H1N1)	273	413	645	144	89	413	790	67	**2,834**
A(H3N2)	15	31	146	22	6	33	74	7	**334**
B/Victoria lineage	92	141	88	25	21	49	254	35	**705**
B/Yamagata lineage	0	0	0	0	0	0	0	0	**0**
Total	**380**	**585**	**879**	**191**	**116**	**495**	**1,118**	**109**	**3,873**

Source: World Health Organization (WHO) Collaborating Centre for Reference and Research on Influenza
*Viruses tested by the WHO Collaborating Centre for Reference and Research on Influenza are not necessarily a random sample of all those in the community and early-year data may be based on limited samples received. There may be up to a month delay on reporting of samples.
† Jurisdiction indicates the residential location for the individual tested, not the submitting laboratory.

Vaccine coverage, effectiveness and match

Vaccine coverage, effectiveness and match for acute respiratory infections are monitored from several data sources in Australia. Refer to the Technical Supplement for more information.

Vaccine coverage

- In Australia, regular COVID-19 vaccinations are the best way to stay protected against severe illness, hospitalisation and death from COVID-19. Most adults should get vaccinated annually and adults aged 75 years and over should get vaccinated every six months.
  - More information on COVID-19 vaccines in Australia is available via the department's COVID-19 webpages or from the National Centre for Immunisation Research and Surveillance (NCIRS).
- Nationally, 8% of adults (aged 18 years and over) have received a COVID-19 vaccine in the last six months (Table 5).
- Nationally, fewer adults have received a COVID-19 vaccine in the last 12 months (11%; Table 5), compared to the 12 months prior (13.8% from 2 October 2023 to 29 September 2024).
- In the last 12 months, vaccine coverage decreased in all age groups, with the largest decrease seen in 65–74 years age group (from 33.8% in the 12 months prior to 26.8% in the last 12 months).
- There is substantial variation in COVID-19 vaccine coverage across age groups, ranging from 4.6% in adults aged 18–64 years to 41.8% in adults aged 75 years and over. Vaccine coverage increases with increasing age (Table 5).
- There is some variation in vaccine coverage across jurisdictions, ranging from 4.2% in the NT to 19.1% in Tas (Table 5).

Table 5: COVID-19 vaccine coverage*†‡ by age group and jurisdiction, Australia, 30 September 2024 to 5 October 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Last 12 months (30 September 2024 to 5 October 2025)									
18–64 years	10.3	4.0	2.1	4.4	4.6	8.6	5.0	4.6	4.6
65–74 years	48.3	24.9	15.1	25.8	27.8	39.9	27.2	27.2	26.8
≥ 75 years	64.7	39.8	26.1	40.7	41.7	56.4	41.1	43.3	41.8
All ages (18 years and over)	18.3	10.2	4.2	10.6	12.1	19.1	11.0	10.8	11.0
Last 6 months (31 March 2025 to 5 October 2025)									
18–64 years	7.6	2.9	1.4	3.2	3.3	6.4	3.6	3.6	3.4
65–74 years	35.8	18.4	11.0	18.1	19.7	30.0	20.1	20.7	19.6
≥ 75 years	48.4	28.5	19.0	28.2	29.0	42.0	29.3	31.5	29.8
All ages (18 years and over)	13.6	7.4	3.0	7.5	8.6	14.3	8.0	8.2	8.0

Source: Australian Immunisation Register (AIR) as at 6 October 2025
* COVID-19 vaccine coverage among the general population uses the most recently available Australian Bureau of Statistics Estimated Resident Population (ERP) as denominator for population data. Age in years is calculated as at the reporting week.
† COVID-19 vaccine coverage is influenced by changes in COVID-19 vaccine recommendations and eligibility criteria. For this reason, caution should be used when comparing coverage rates in the current 12 month period to previous 12 month periods. Coverage data in these tables may differ slightly from coverage estimates in other reports due to differences in calculation methodologies and/or different data download dates.
‡ Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Population denominator data used to calculate COVID-19 vaccine coverage are based on an individual's residential address. Total rows will include individuals where jurisdiction was missing.

- Nationally, 3.4% of Aboriginal and Torres Strait Islander adults (aged 18 years or over) have received a COVID-19 vaccine in the last six months (Table 6).
- Nationally, fewer Aboriginal and Torres Strait Islander adults have received a COVID-19 vaccine in the last 12 months (4.7%; Table 6), compared to the 12 months prior (6.5% from 2 October 2023 to 29 September 2024).
- In the last 12 months, vaccine coverage decreased in all age groups of Aboriginal and Torres Strait Islander people, with the largest decrease seen in ≥ 75 years age group (from 34.5% in the 12 months prior to 27.3% in the last 12 months).
- Among Aboriginal and Torres Strait Islander people there is substantial variation in COVID-19 vaccine coverage across age groups, ranging from 2.7% in adults aged 18–64 years to 27.3% in adults aged 75 years and over. Vaccine coverage increases with increasing age (Table 6).
- Among Aboriginal and Torres Strait Islander people, there is slight variation in vaccine coverage across jurisdictions, ranging from 2.6% in the NT to 9.7% in Tas (Table 6).

Table 6: COVID-19 vaccine coverage*†‡ among Aboriginal and Torres Strait Islander populations by age group and jurisdiction, Australia, 30 September 2024 to 5 October 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Last 12 months (30 September 2024 to 5 October 2025)									
18–64 years	6.1	2.7	1.9	2.5	2.7	5.5	3.9	2.2	2.7
65–74 years	35.2	18.9	9.0	17.4	17.5	32.7	20.4	16.3	17.9
≥ 75 years	51.1	29.2	13.5	25.7	29.6	43.8	32.7	26.0	27.3
All ages (18 years and over)	9.4	5.1	2.6	4.3	4.8	9.7	6.6	3.8	4.7
Last 6 months (31 March 2025 to 5 October 2025)									
18–64 years	4.7	2.0	1.2	1.8	2.0	4.1	2.8	1.8	2.0
65–74 years	26.3	13.9	6.2	12.4	12.8	24.6	14.9	12.4	13.0
≥ 75 years	39.6	20.8	10.1	18.4	20.3	31.1	23.7	20.2	19.6
All ages (18 years and over)	7.1	3.7	1.8	3.1	3.5	7.2	4.7	3.0	3.4

Source: Australian Immunisation Register (AIR) as at 6 October 2025
* COVID-19 vaccine coverage among Aboriginal and Torres Strait Islander populations is based on the AIR population as known at the reporting week. Age in years is calculated as at the reporting week.
† COVID-19 vaccine coverage is influenced by changes in COVID-19 vaccine recommendations and eligibility criteria. For this reason, caution should be used when comparing coverage rates in the 12 month period to previous 12 month periods. Coverage data in these tables may differ slightly from coverage estimates in other reports due to differences in calculation methodologies and/or different data download dates.
‡ Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Population denominator data used to calculate COVID-19 vaccine coverage are based on an individual's residential address. Total rows will include individuals where jurisdiction was missing.

- Influenza virus strains change year to year, so annual vaccination before the peak of the influenza season provides Australians with the best protection against influenza and its complications. The seasonal influenza vaccine is recommended for everyone aged six months and over.
    - More information on influenza vaccines in Australia is available via the department's influenza vaccine webpages or from NCIRS.
- Nationally, influenza vaccine coverage is 30.6% for 2025 so far (Table 7); however, remains lower than coverage at the same time in 2023 and 2022.
- There is substantial variation in influenza vaccine coverage across age groups, ranging from 14.7% in children aged 5–14 years to 61.3% in adults aged 65 years and over (Table 7). The current trend should be interpreted with care as people aged 5–64 years are generally not eligible for free seasonal influenza vaccine under the National Immunisation Program.
- There is some variation in influenza vaccine coverage across jurisdictions, ranging from 25.3% in the NT to 40.2% in the ACT (Table 7).
- Among Aboriginal and Torres Strait Islander populations, there is substantial variation in influenza vaccine coverage across age groups, ranging from 12% in children aged 5–14 years to 57.8% in adults aged 65 years and over (Table 7).
- Among Aboriginal and Torres Strait Islander populations, there is some variation in influenza vaccine coverage across jurisdictions, ranging from 19.3% in SA to 33.5% in the NT (Table 7).

Table 7: Influenza vaccine coverage*†‡ by age group and jurisdiction, Australia, 1 March to 5 October 2025

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Age groups									
6 months to <5 years	53.9	28.7	40.9	23.2	32.3	35.1	35.3	26.9	30.0
5–14 years	24.0	13.5	13.9	13.4	15.6	15.2	16.3	15.4	14.7
15–49 years	32.8	19.6	22.7	18.6	23.9	23.7	23.9	18.9	21.1
50–64 years	44.5	30.2	26.3	31.7	36.3	39.4	34.4	31.0	32.5
≥ 65 years	65.5	58.9	38.0	61.5	66.9	68.8	62.6	60.8	61.3
All ages (6 months and over)	40.2	29.2	25.3	28.6	35.0	36.7	32.7	28.6	30.6
Aboriginal and Torres Strait Islander populations									
6 months to <5 years	34.5	19.5	40.8	15.9	19.4	24.4	24.3	19.9	20.4
5–14 years	0.0	11.2	22.5	10.8	12.5	12.7	12.5	11.6	12.0
15–49 years	26.3	17.2	31.6	16.1	20.0	19.8	19.6	15.9	18.5
50–64 years	46.2	36.8	44.9	35.4	38.6	45.8	37.0	33.2	37.2
≥ 65 years	69.8	63.2	48.0	61.1	0.0	70.5	64.2	54.9	57.8
All ages (6 months and over)	27.2	22.1	33.5	20.2	19.3	26.7	24.8	19.8	22.5

Source: Australian Immunisation Register (AIR) as at 6 October 2025
* Influenza vaccine coverage uses the AIR population as the denominator. Coverage data in these tables may differ slightly from coverage estimates in other reports due to differences in calculation methodologies and/or different data download dates.
† Age is calculated based on the person's age as at 1 July of the reporting year.
‡ From the report ending 13 July 2025, jurisdiction is based on the person's address on the AIR rather than an individual's residential address as recorded on Medicare. Total rows will include individuals where jurisdiction was missing. In addition, to align with departmental reporting methodologies, both the numerator (number of persons vaccinated) and denominator (AIR population) for influenza vaccine coverage only consider person records with a Personal Identification Number that was able to be matched to Medicare. Person records with a Synthetic Identification Number are now excluded from both numerator and denominator. For these reasons, influenza vaccine coverage metrics in previous Australian Respiratory Surveillance Reports and coverage metrics from the report ending 13 July 2025 moving forward should be interpreted with care.

- Infants can be protected against severe illness from RSV through the vaccination of pregnant people or the direct administration of monoclonal antibodies like nirsevimab. These are part of the National RSV Maternal and Infant Protection Program which launched on 3 February 2025 and includes both the National Immunisation Program funded Abrysvo vaccine and jurisdictional nirsevimab programs.
  – More information on RSV immunisation in Australia is available via the department's RSV vaccine webpages or from NCIRS.
- Since the commencement of the National RSV Mother and Infant Protection Program, 132,053 Abrysvo doses have been administered to pregnant people nationally (Table 8).
- While high maternal vaccine uptake is a positive indicator of maternal program success, it may result in lower nirsevimab uptake rates in infants. This is because maternal antibodies passed to the infant can provide protection against RSV, potentially reducing the need for infant immunisation.

Table 8: Number of doses of Abrysvo administered to pregnant people by jurisdiction*, Australia, 3 February to 5 October 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
15–24 years	197	3,345	241	3,002	741	364	1,907	1,279	11,076
25–39 years	3,075	35,656	1,079	20,624	7,943	2,444	31,336	11,725	113,882
40–54 years	202	2,363	51	1,074	450	101	2,151	703	7,095
Total (15–54 years)	3,474	41,364	1,371	24,700	9,134	2,909	35,394	13,707	132,053

Source: Australian Immunisation Register (AIR) as at 6 October 2025
* Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Total rows will include individuals where jurisdiction was missing.

- In the last six months, 20% of infants (aged < 8 months) have received nirsevimab (Table 9).
- There is substantial variation in nirsevimab uptake in infants across jurisdictions, ranging from 12.2% in NSW to 39.6% in WA (Table 9).
- The current trend is likely due to variation in the seasonality and eligibility criteria between state and territory programs, as well as the presence of previous nirsevimab programs. Some state and territory programs are seasonal (from 1 April to 30 September), whereas others are year-round. In states with seasonal programs (SA, Tas, Vic, and parts of WA), uptake may appear disproportionately lower at this time of the year. In addition, Qld and WA had nirsevimab programs in 2024, which may contribute to higher nirsevimab uptake in 2025 in these states.

Table 9: Nirsevimab (Beyfortus) uptake in the last six months*†‡ by age group and jurisdiction, Australia, 31 March 2025 to 5 October 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Infants (aged < 8 months)	12.3	12.2	16.4	14.8	30.7	36.9	22.5	39.6	20.0
Young children (aged ≥ 8 to 24 months)	0.2	0.4	0.3	0.2	1.1	1.5	1.0	1.5	0.7

Source: Australian Immunisation Register (AIR) as at 6 October 2025
* Reporting of RSV monoclonal antibodies to the AIR is not compulsory; therefore, uptake is likely to be underestimated. Uptake data in these tables may differ slightly from estimates in other reports due to differences in calculation methodologies and/or different data download dates.
† For infants and young children vaccinated, age in months is calculate as months between the immunisation encounter and date of birth rounded down as at the reporting date. For the infant and young children population, age in months is calculated as months between the AIR data extract date and date of birth rounded down as at the reporting date.
‡ Jurisdiction is based on the state or territory in which a vaccine was administered and may differ from a person's residential address. Total rows will include individuals where jurisdiction was missing. Population denominator data used to calculate nirsevimab uptake are based on an individual's residential address as recorded on Medicare.

Vaccine effectiveness

ASPREN and FluCAN for the Global Influenza Vaccine Effectiveness (GIVE) Collaboration

- Vaccine effectiveness is the reduction in risk of influenza and its complications in those vaccinated, compared to those not vaccinated. Initial Australian studies suggest that in 2025, vaccinated individuals are roughly 53% less likely to attend general practice or be hospitalised with influenza than unvaccinated people.
- Estimated vaccine effectiveness against general practice attendance with influenza overall is 56% (95% Confidence Interval [CI]: 40%, 68%).
  - Estimated vaccine effectiveness against general practice attendance with influenza A(H1N1) is 51% (95% CI: 26%, 67%). No estimates are available for vaccine effectiveness against general practice attendance with influenza A(H3N2) due to low case numbers.
  - Estimated vaccine effectiveness against general practice attendance with influenza B is 60% (95% CI: 27%, 78%).
  - Estimated vaccine effectiveness against general practice attendance with influenza is comparable between children (less than 18 years) (61%, 95% CI: 20%, 81%) and adults aged 65 years and over (62%, 95%CI: 41%, 75%), and lower in those aged 18–64 years (32%, 95% CI: -38%,66%).
  - These vaccine effectiveness estimates against general practice attendance for influenza are slightly lower than observed in 2024 (62% overall, 95% CI: 45 to 74). Vaccine effectiveness estimates were higher in those 65 years and over in 2024 and lower in children (less than 18 years) in 2024 compared to 2025. Notably, vaccine effectiveness estimates against general practice attendance with influenza A H1N1, which also circulated at high levels in 2024, were substantially lower in 2025 than in 2024 (74%, 95%CI: 45 to 88 in 2024).
- Estimated vaccine effectiveness against hospitalisation with influenza overall is 49% (95% CI: 42%, 56%).
  - Estimated vaccine effectiveness against hospitalisation with influenza A(H1N1) is 42% (95% CI: 29%, 52%), and for influenza A(H3N2) is 60% (95% CI: 4%, 84%).
  - Estimated vaccine effectiveness against hospitalisation with influenza B is 78% (95% CI: 68%, 85%).
  - Estimated vaccine effectiveness against hospitalisation with influenza is much higher in children <18 years of age (67%, 95% CI: 58%, 74%), compared to adults aged 65 years and over (38%, 95% CI: 19%, 52%), and those aged 18–64 year (22%, 95% CI: -5%, 43%).
  - These vaccine effectiveness estimates against hospitalisation with influenza are lower when compared to 2024 estimates (56% overall, 95% CI: 48 to 63). Vaccine effectiveness estimates in the 18 – 64 years and 65 years and over age groups are significantly lower compared to 2024 (60%, 95% CI: 35 to 77 and 81%, 95% CI: 50 to 93 respectively) but remain consistent in children less than 18 years.

Please note, these figures are based on initial analyses on incomplete data and the final vaccine effectiveness estimates for 2025 may differ.

Vaccine match

- Refer to the Technical Supplement for information on the 2025 southern hemisphere influenza vaccines composition.
- In the year to date, 99.4% (2,817/2,834) of influenza A(H1N1) isolates, 92.2% (308/334) of influenza A(H3N2) isolates and 98.2% (692/705) of influenza B/Victoria lineage isolates characterised have been antigenically similar to the corresponding 2025 vaccine components.