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 (3 November to 30 November 2025) and earlier severity reporting periods (up to 16 November 2025).

In the community: In the last month, influenza-like illness among national helpline callers and the rate of helpline callers referred to seek urgent medical care was higher than the previous month. More community survey participants self-reported new fever and cough symptoms and taking time off work due to respiratory illness. COVID-19 cases increased in the last month but remain lower than at the same time in previous years. Nationally, the number of influenza cases has been consistently increasing since late October, which is unusual for this time of year. Current case numbers remain considerably higher than observed at the same time period in previous seasons, likely driven by influenza A(H3N2), clade 2a.3a.1, subclade K. RSV cases continued to decrease in the last month, following the downward trend in national case numbers observed since July 2025.

In general practice: In the last month, 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 month. From June to November, influenza-like illness consultation rates have been consistently higher than historical trends. Like influenza case notification trends, influenza-like illness consultation rates have not yet returned to the interseasonal levels observed in prior years.

In hospitals: Sentinel hospital admissions with severe acute respiratory infections have been decreasing since a peak in July. The proportion of patients who were admitted directly to intensive care at a sentinel hospital site remains low. At sentinel hospitals, children (those aged 16 years and younger) were most commonly admitted with RSV, while adults were more commonly admitted with influenza. Sentinel intensive care admissions with severe acute respiratory infections have been declining since late June and most patients in 2025 to date have been admitted with influenza. A higher proportion of intensive care admissions with influenza and parainfluenza required invasive mechanical ventilation; however, the duration of intensive care stay has been relatively similar between illnesses. In the last month, there were more COVID-19 cases occupying intensive care beds across Australia than in the previous month.

Deaths: COVID-19 has been the leading cause of acute respiratory infection mortality across the majority of 2023–2025. In August and September 2025, the number of deaths involving influenza (both *due* to and *with*) have exceeded the number of deaths involving COVID-19. 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 last month, test positivity for SARS-CoV-2 and influenza increased whilst test positivity decreased RSV. The SARS-CoV-2 variant under monitoring, NB.1.8.1, remains the dominant SARS-CoV-2 variant in the last 28 days (3 November to 30 November 2025) accounting for 35.6% of sequences in Australia.

Vaccine coverage, effectiveness and match: Nationally, 10.9% of adults have received a COVID-19 vaccine in the last 12 months. Influenza vaccine coverage was 30.7% in 2025. Since the commencement of the National RSV Mother and Infant Protection Program, 161,093 Abrysvo doses have been administered. In the last six months, nirsevimab uptake is 11.5% 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. Since October, there has been a notable increase in influenza A(H3N2) viruses that have shown reduced reactivity to the southern hemisphere 2025 vaccine strain; however, these viruses show reasonable reactivity to the 2026 proposed southern hemisphere vaccine strain. Further analysis is required to understand this change.

Australian Respiratory Surveillance Report

This report was prepared by Lauren Kutzner, Lauren Welsh, Algreg Gomez and Jenna Hassall 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:

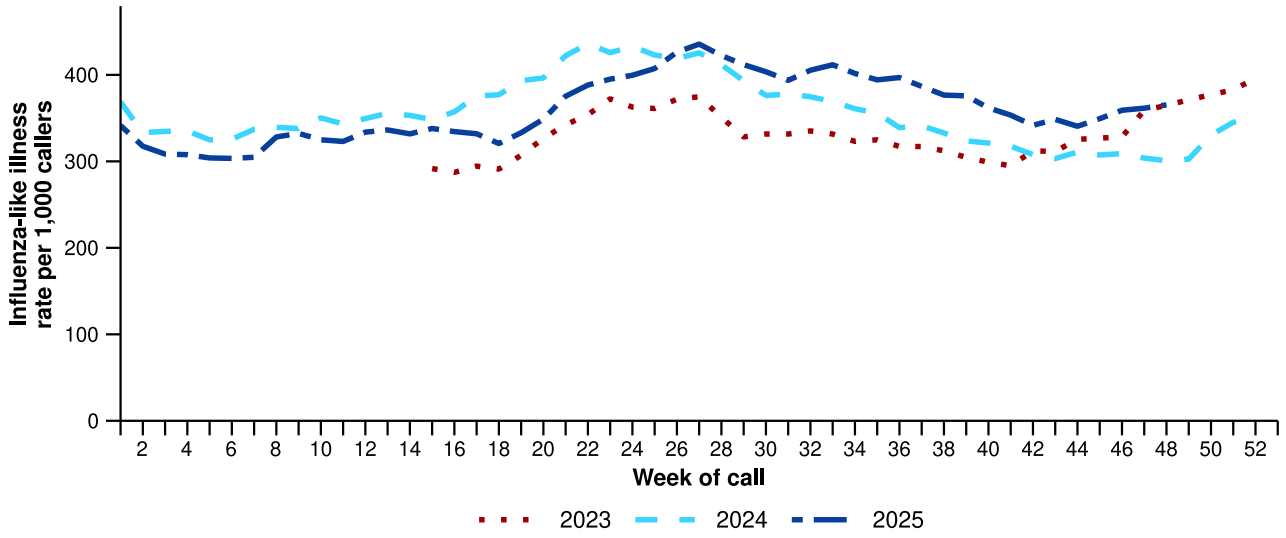
- Due to the dynamic nature of the surveillance systems used in this report, surveillance data are considered preliminary and subject to change as updates are received, with the most recent weeks considered particularly incomplete. Data in this report may vary from data reported in other national reports 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 3 November to 30 November 2025 and where comparisons to the previous month are made, this includes 6 October to 2 November 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 3 December 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 20 October to 16 November 2025 unless specified otherwise. Where comparisons to the previous severity month are made this includes 22 September to 19 October 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 month (3 November to 25* November 2025), there were more Healthdirect helpline callers with influenza-like illness (358 per 1,000 callers per month) than in the previous month (346 per 1,000 callers per month) (Figure 1).
  - * Note Healthdirect data are unavailable from 25 November 2025.
- Rates of influenza-like illness among helpline callers peaked in July and have since declined but remained higher than at the same time in 2023 and 2024. Since early November, rates have been increasing slightly, in line with trends observed at the same time in previous years (Figure 1).

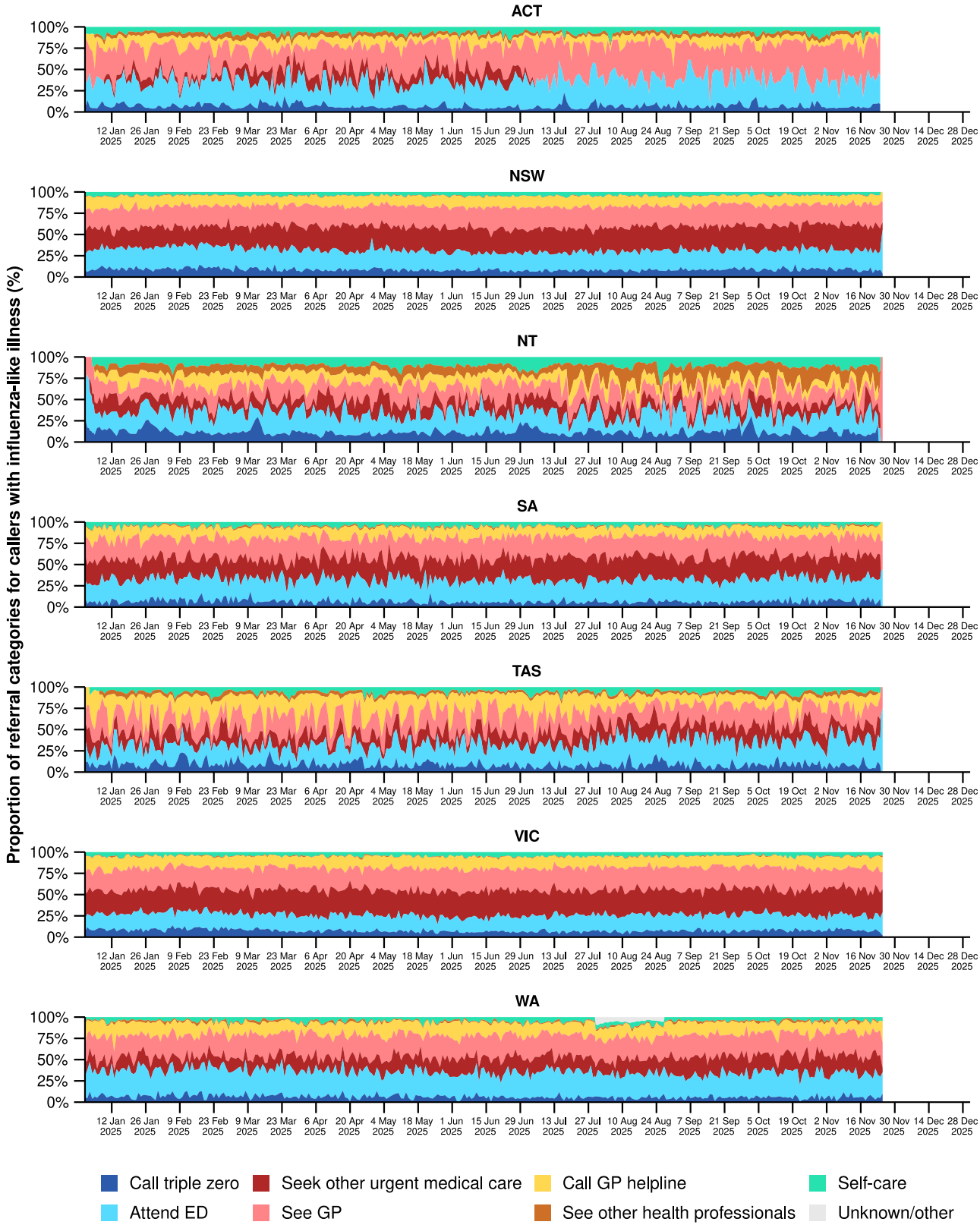
Figure 1: Rate of influenza-like illness per 1,000 helpline callers by year and week of call*, Australia†, 22 March 2023 to 25 November 2025



Source: Healthdirect Australia
* Healthdirect data prior to 22 March 2023 are unavailable as prior to this date a different data collection method was used. Healthdirect data are unavailable from 25 November 2025.
† 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 month (3 November to 25* November 2025), there were slightly more Healthdirect helpline callers with influenza-like illness referred to seek urgent medical care (182 per 1,000 callers per month) than in the previous month (176 per 1,000 callers per month) (Figure 2).
  - * Note Healthdirect data are unavailable from 25 November 2025.
  - 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 month, referral pathways for influenza-like illness varied across Australia. 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 and the NT had a higher proportion of callers who were recommended to attend a hospital emergency department or call triple zero (Figure 2).
  - These differences may reflect variations in healthcare access and service models and should be interpreted with caution.

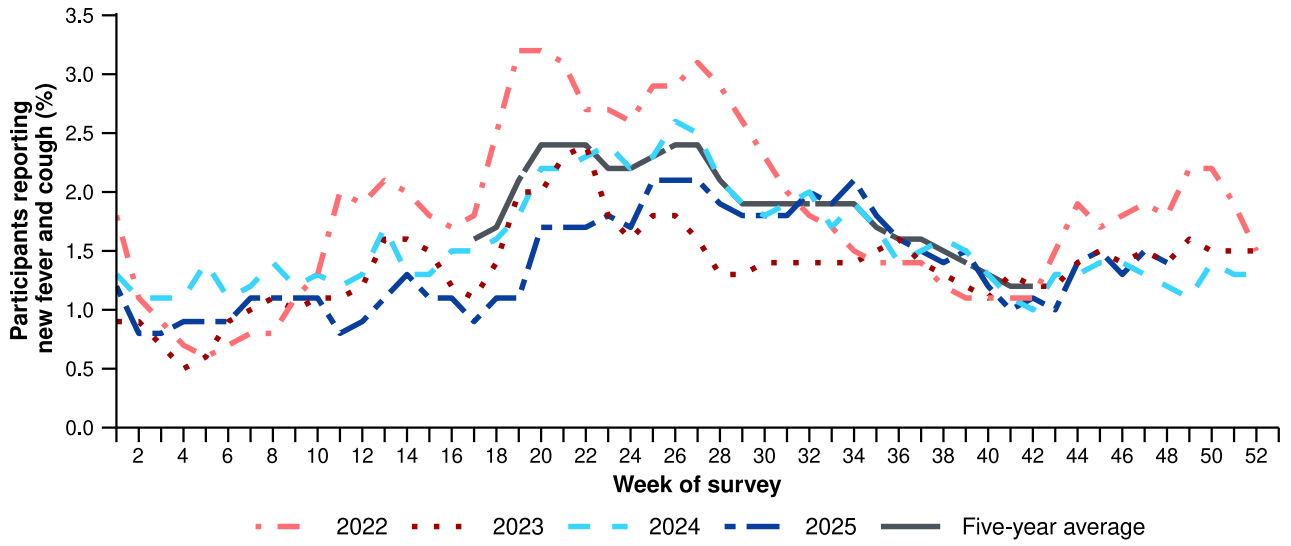
Figure 2: Proportion of referral categories* for helpline callers with influenza-like illness by jurisdiction† and call date, Australia, 1 January to 25 November 2025



Source: Healthdirect Australia. Healthdirect data are unavailable from 25 November 2025.
* 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 month (3 November to 30 November 2025), slightly more FluTracking survey participants reported new fever and cough symptoms (1.4%), than in the previous month (1.1%) (Figure 3).
- Following a decreasing trend since the small August peak, the weekly percentage of FluTracking participants reporting new fever and cough symptoms has been increasing since early November, similar to trends observed at the same time in previous years (Figure 3).
- In the last month, more survey participants with new fever and cough symptoms used a rapid antigen test (RAT) (53.0%; 543/1,024) than a polymerase chain reaction (PCR) test (12.3%; 126/1,024) to test for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
- Self-reported SARS-CoV-2 RAT positivity was higher in the last month (16.9%; 92/543) than in the previous month (12.8%; 88/689). Self-reported SARS-CoV-2 PCR positivity was higher in the last month (7.9%; 10/126) than in the previous month (3.3%; 6/182).
- In the last month, 11.3% (116/1,024) of survey participants with new fever and cough symptoms used a PCR test to test for influenza. Self-reported influenza PCR positivity was higher this month (32.8%; 38/116), than in the previous month (23.7%; 42/177).
- In the last month, more survey participants reported taking three or more days off work or normal duties due to fever and cough symptoms (48.7%; 499/1,024), than in the previous month (47.5%; 665/1,399).

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 30 November 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 month (3 November to 30 November 2025), there was a 15.6% increase in COVID-19 cases, a 26.1% increase in influenza cases, and a 20.1% decrease in RSV cases.

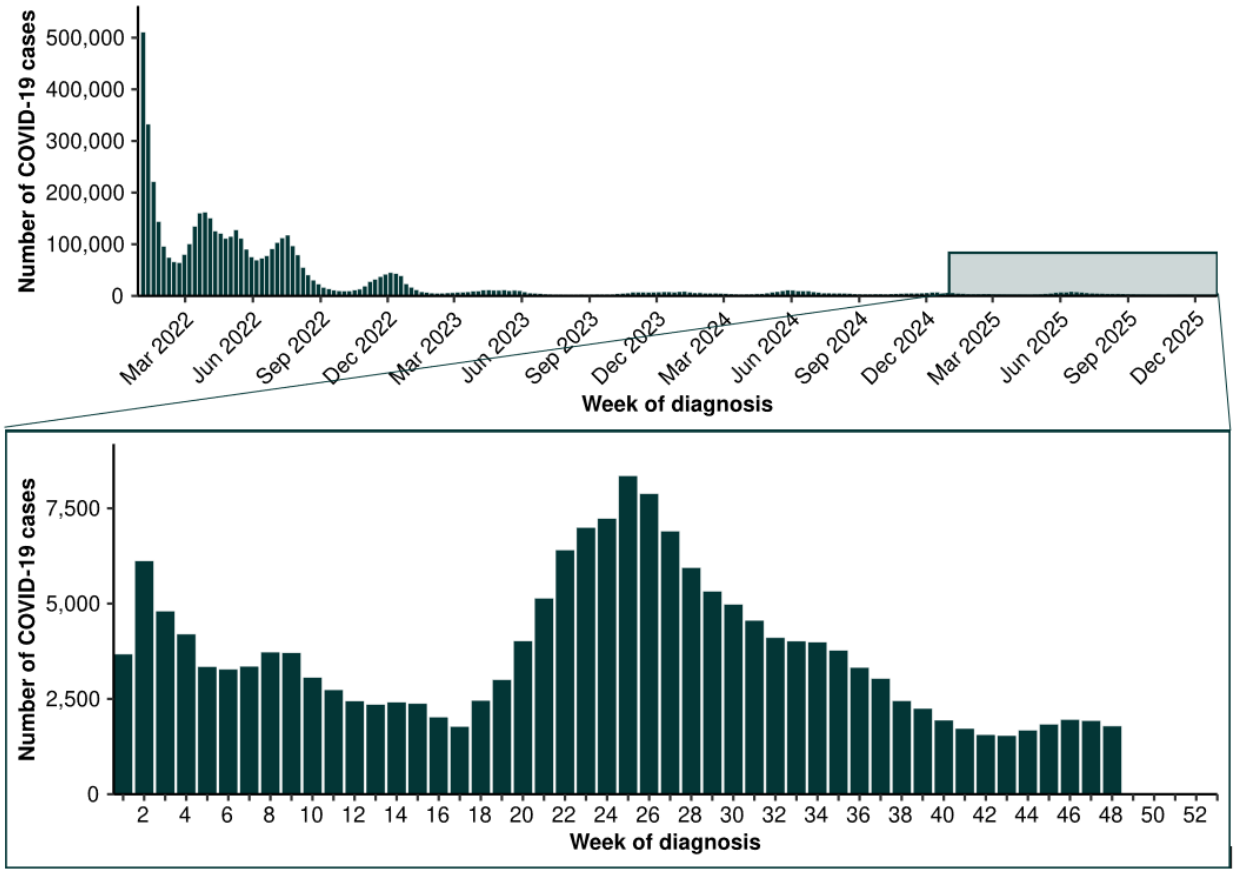
Table 1: Notified cases and notification rate per 100,000 population by disease, five-year age group, and jurisdiction*†, Australia, 1 January to 30 November 2025

	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	947	17,770	1,178	4,296	54,472	3,610	1,833	77,242	5,119
5–9	448	5,463	339	5,241	66,751	4,144	295	12,798	794
10–14	463	5,724	342	4,340	47,792	2,854	144	5,748	343
15–19	300	5,976	359	3,081	30,101	1,810	151	3,930	236
20–24	256	6,088	340	1,695	17,431	974	109	3,114	174
25–29	290	7,500	376	1,794	16,871	845	130	3,627	182
30–34	390	9,162	449	1,567	22,091	1,083	152	4,621	227
35–39	478	10,490	529	1,561	28,373	1,430	144	4,629	233
40–44	428	10,020	541	1,538	28,599	1,544	142	4,139	223
45–49	354	8,563	526	1,156	22,115	1,358	153	3,868	238
50–54	329	8,598	509	1,109	20,105	1,189	198	4,855	287
55–59	335	8,344	544	1,121	18,282	1,192	211	5,273	344
60–64	313	8,859	577	1,185	17,913	1,167	226	5,934	387
65–69	342	9,153	673	1,203	16,385	1,205	257	6,169	454
70+	1,841	55,645	1,666	4,096	54,655	1,636	1,180	26,629	797
Jurisdiction									
ACT	175	2,894	610	408	8,265	1,743	53	2,955	623
NSW	3,033	78,939	930	13,509	171,540	2,022	1,671	69,884	824
NT	164	1,496	586	582	4,741	1,858	240	1,152	452
Qld	1,160	36,594	655	5,669	91,789	1,643	1,681	32,840	588
SA	535	10,902	581	2,855	33,062	1,760	351	12,665	674
Tas	148	2,798	486	816	8,365	1,454	112	2,960	514
Vic	1,886	32,023	459	9,187	109,997	1,576	828	37,641	539
WA	414	11,845	399	1,980	34,497	1,163	389	12,493	421
Total	**7,515**	**177,491**	**652**	**35,006**	**462,256**	**1,699**	**5,325**	**172,590**	**634**

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.

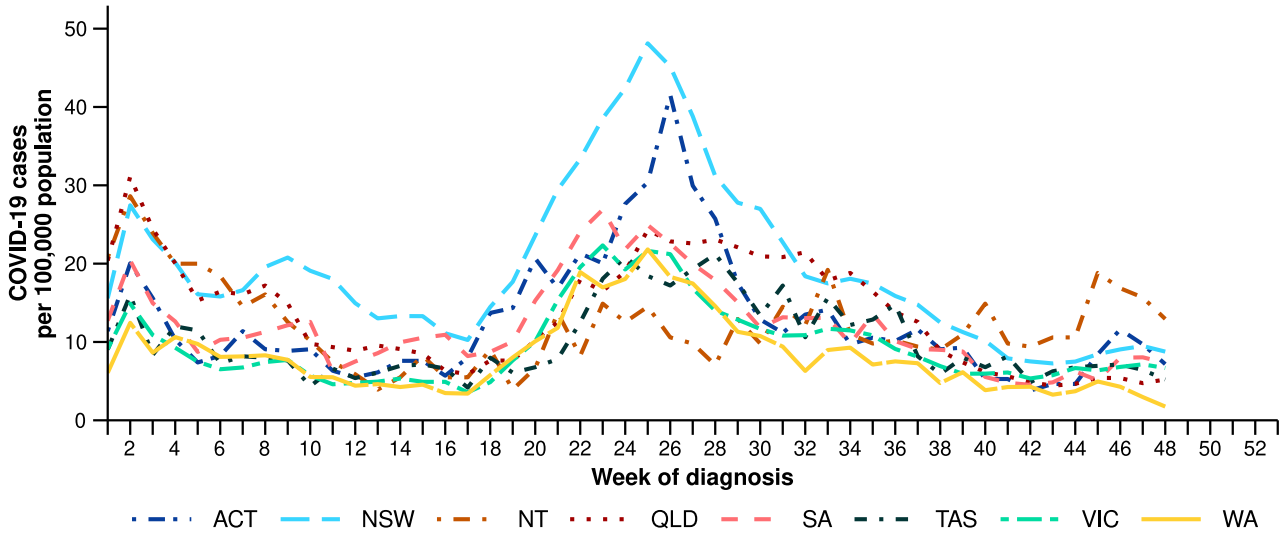
- In the last month, nationally the number of COVID-19 cases increased. The increasing trend is consistent with trends at the same time in 2023 and 2024 where increasing case numbers were observed from October onwards before a summer peak (Figure 4).
- The number of COVID-19 cases this year to date (n=177,491) is 35.1% fewer than the number of cases observed in the same time period last year (n=273,615) (Figure 4).
- In the last month, COVID-19 notification rates increased or remained relatively stable in most jurisdictions compared with the previous month, except in WA where a decrease in COVID-19 notification rates was observed (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 30 November 2025



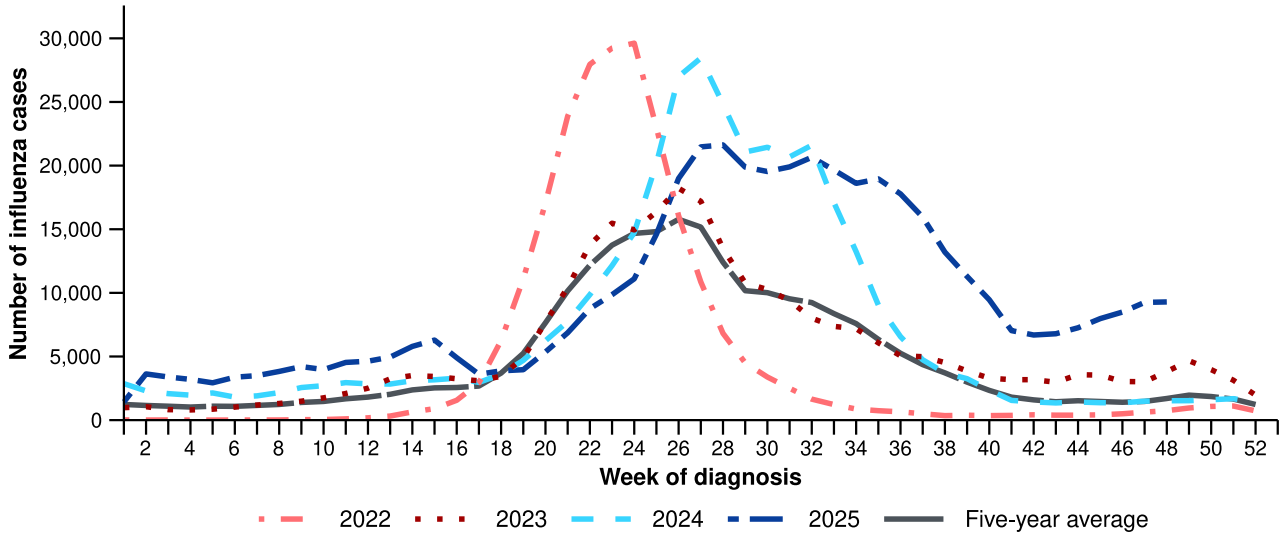
Source: National Notifiable Diseases Surveillance System (NNDSS)

Figure 5: Notification rates* per 100,000 population for COVID-19 cases by state or territory and week of diagnosis, Australia, 1 January to 30 November 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 30 November 2025

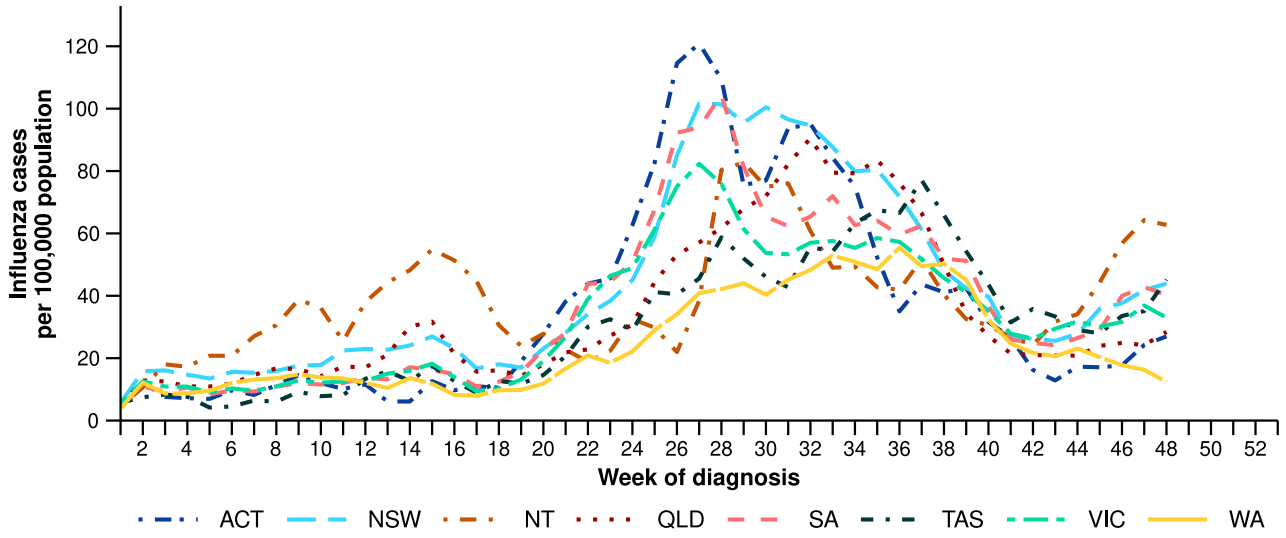


Source: National Notifiable Diseases Surveillance System (NNDSS)
* The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. As such, the five-year average includes the years 2018 to 2019 and 2022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

- Nationally, the number of influenza cases has been consistently increasing since late October, which is unusual for this time of year. Current case numbers remain considerably higher than observed at the same time period in previous seasons (Figure 6).
  - Several factors may be contributing to this out-of-season increase but the main driver is most likely influenza A(H3N2), in particular clade 2a.3a.1, subclade K.
  - Subclade K has developed seven new mutations, making it different enough from the 2025 southern hemisphere influenza vaccine reference strain (subclade J.2). As a result, the influenza A(H3N2) subclade K strain now circulating is less responsive to antibodies produced by this year's vaccine compared to the influenza A(H3N2) strain circulating earlier in the season.

  - Despite this, the influenza vaccine still provides important protection against severe illness and complications from influenza. The current influenza A(H3N2) subclade K viruses also show reasonable match to the 2026 proposed southern hemisphere vaccine strain.
  - This situation reflects what has recently been reported in northern hemisphere countries, where the influenza season has started unusually early.
- The number of influenza cases this year to date (n=462,256) is 28.9% more than the number of cases observed in the same time period last year (n=358,671). This can be attributed to a prolonged peak in cases between late June to mid-August 2025, a slower decrease in case numbers than observed in previous seasons and elevated interseasonal activity (Figure 6).
- In the last month, influenza notification rates remained increased across most jurisdictions compared with the previous month, except in WA where influenza notification rates have continued to decrease (Figure 7).
- In the year to date, influenza notification rates remain highest in children aged 5–9 years and children aged 0–4 years. In the year to date, influenza notification rates are highest NSW and lowest in WA (Table 1).

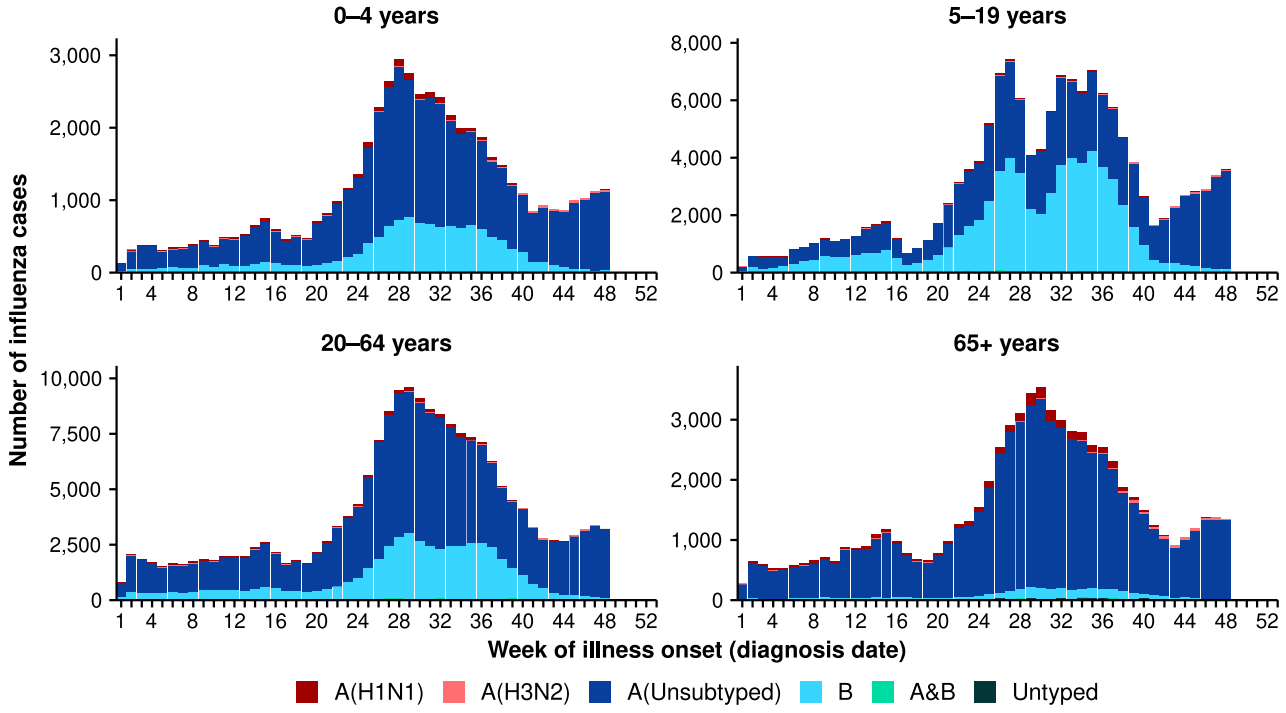
Figure 7: Notification rates* per 100,000 population for influenza cases by state or territory and week of diagnosis, Australia, 1 January to 30 November 2025



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.

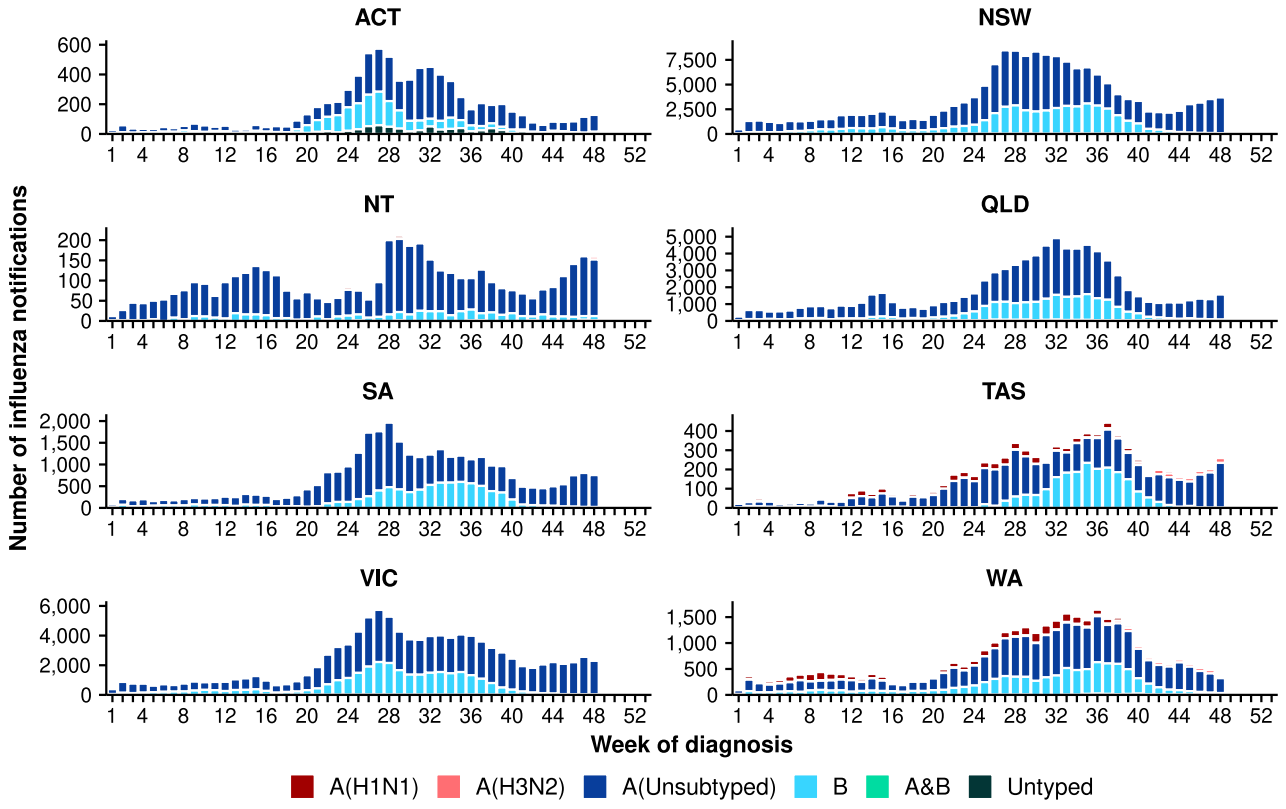
- In the last month, most influenza notifications were influenza A(Unsubtyped) (93.7%; 32,809/35,006), followed by influenza B (3.6%; 1,265/35,006), then influenza A(H3N2) (1.9%; 678/35,006), influenza untyped (0.5%; 168/35,006) and influenza A(H1N1) (0.2%; 77/35,006). In the last month, there were nine 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 has been the highest in the 5–19 years age group. However, the proportion of influenza B has been decreasing across all age groups since late September (Figure 8).
- In the year to date, influenza A(Unsubtyped) has accounted for most influenza cases across all jurisdictions (Figure 9). All jurisdictions have experienced increased numbers of influenza B cases, though the proportion of influenza B compared with influenza A has been decreasing in all jurisdictions since late September (Figure 9). Since late September there has been an increase in the number of influenza A(H3N2) subtyped, particularly in the NT, 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 30 November 2025



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

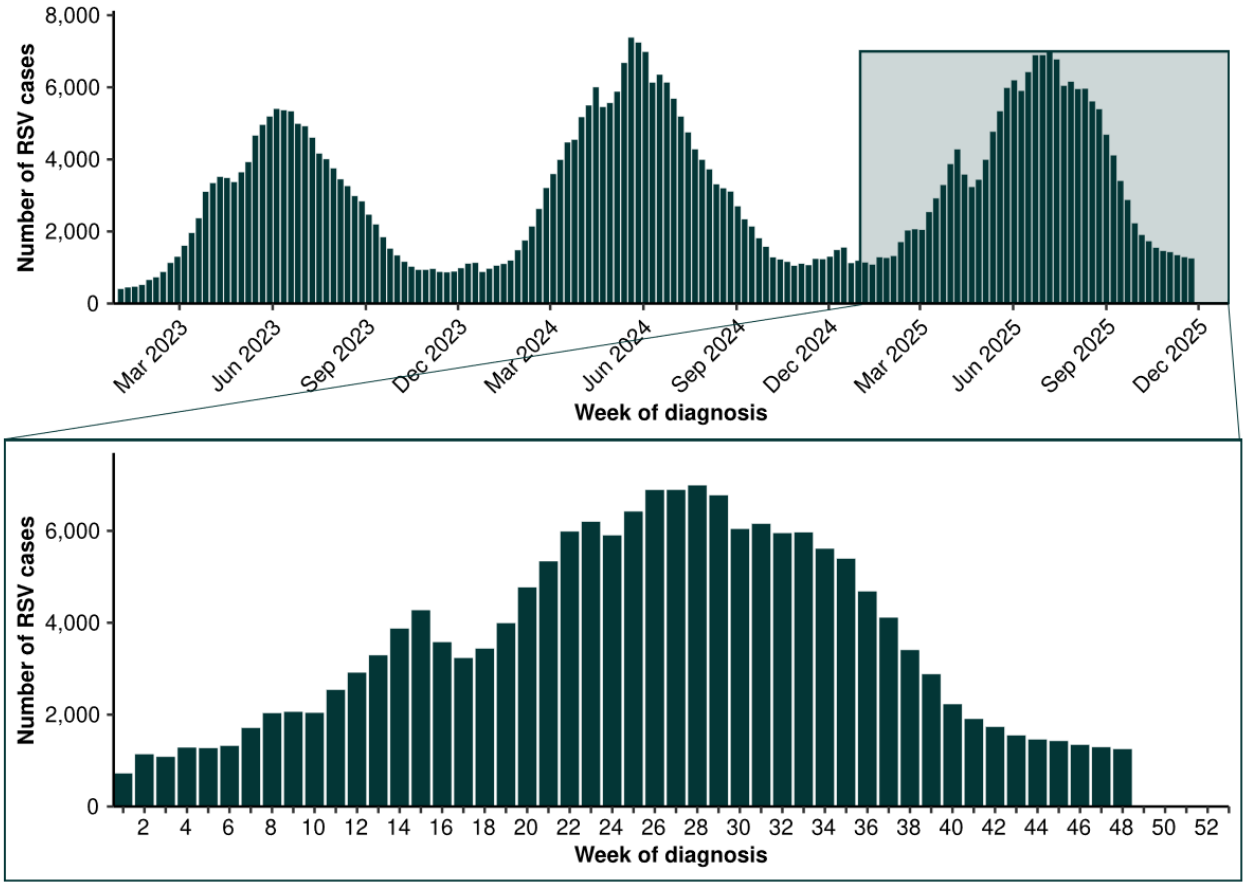
Figure 9: Notified influenza cases by influenza subtype, jurisdiction*, and week of diagnosis, Australia, 1 January to 30 November 2025



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

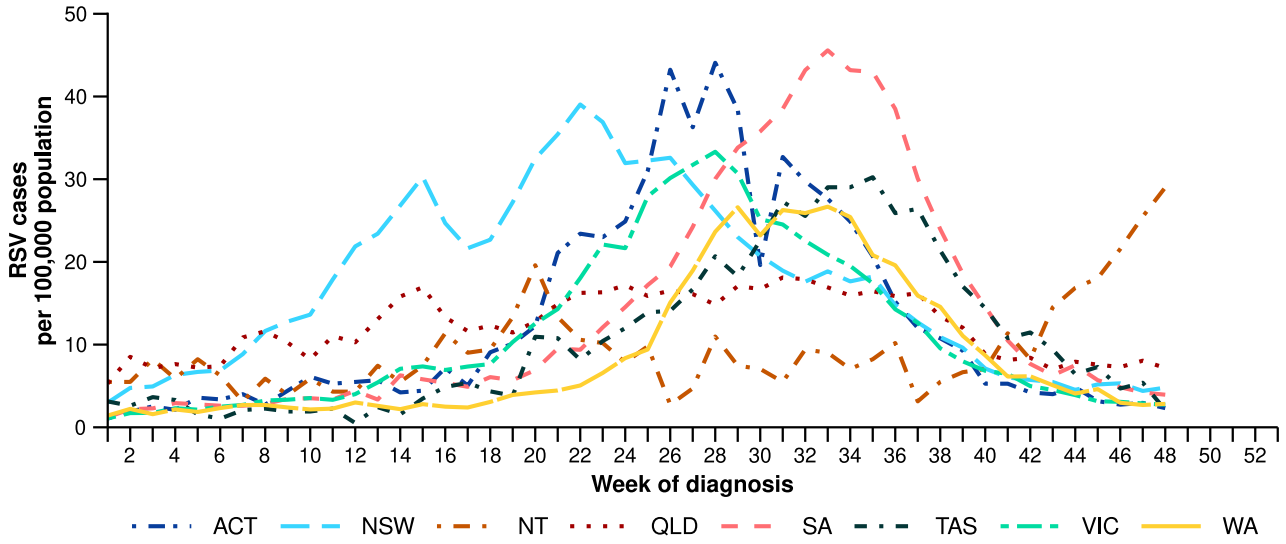
- In the last month, the number of RSV cases nationally continued to gradually decrease following the peak in case numbers observed in July (Figure 10).
- The number of cases this year to date (n=172,590) is 1.6% more than the number of cases observed in the same time period last year (n=169,910) (Figure 10).
- In the last month, RSV notification rates remained relatively similar or decreased across most jurisdictions compared to the previous month, except in the NT where notification rates continued to steadily increase (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 WA (Table 1).

Figure 10: Notified RSV cases by year and week of diagnosis*, Australia, 2023 to 30 November 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 30 November 2025



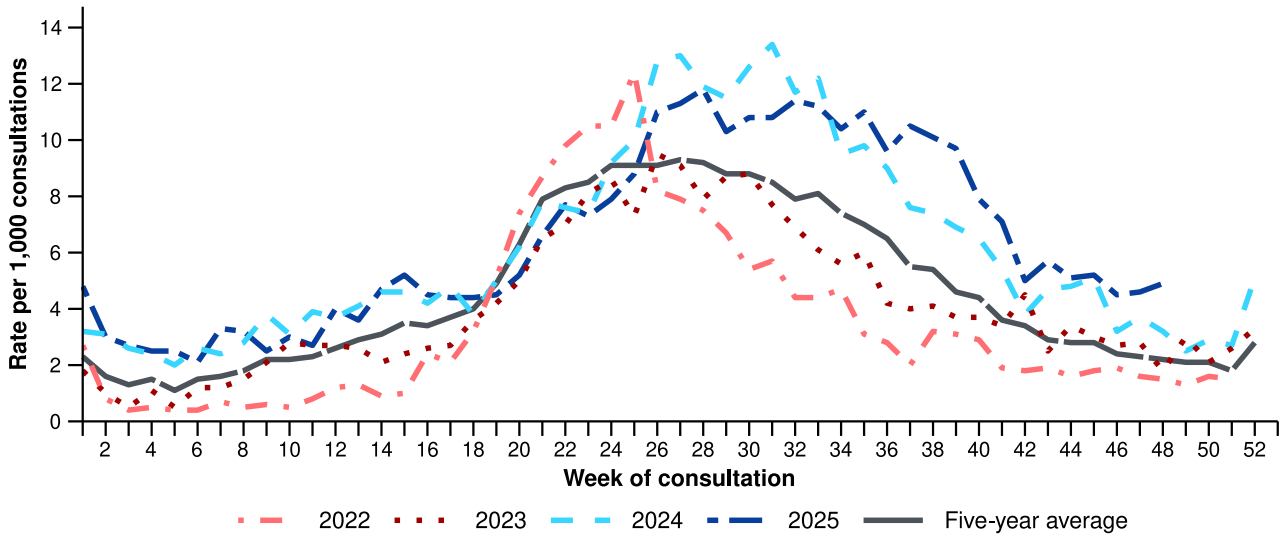
Source: National Notifiable Diseases Surveillance System (NNDSS)
* Rate per 100,000 population for the given time period. Population data are based on the Australian Bureau of Statistics (ABS) Estimated Resident Population (ERP) for the reference period June 2024, released 12 December 2024.

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 month (3 November to 30 November 2025), there were fewer general practice consultations for influenza-like illness (4.8 notifications per 1,000 consultations per month) compared to the previous month (5.7 notifications per 1,000 consultations per month) (Figure 12).
- From late June to October, influenza-like illness consultation rates have been elevated and consistently higher than in 2022, 2023 and the five-year average. During this time, influenza-like illness consultation rates have been relatively consistent with or higher than those observed in 2024 (Figure 12).
- Like influenza case notification trends, influenza-like illness consultation rates have not yet returned to the interseasonal levels observed in prior years or the five-year average (Figure 6; Figure 12).

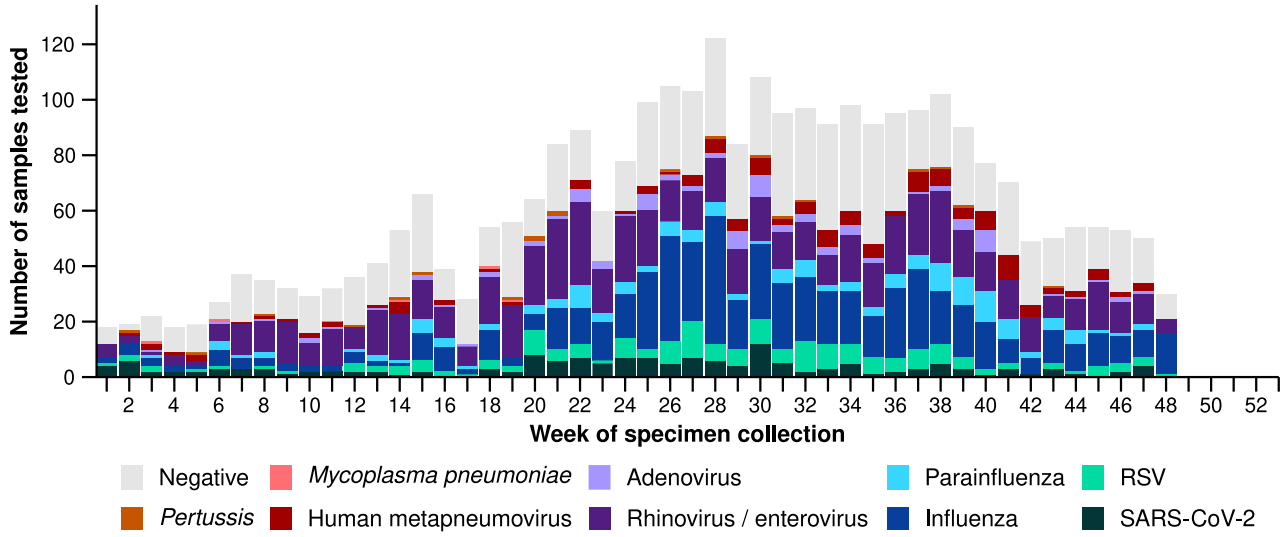
Figure 12: Rate of influenza-like illness notifications per 1,000 consultations per week in sentinel general practice sites compared with the five-year average by year and week of consultation*†, Australia, 2022 to 30 November 2025



Source: Australian Sentinel Practices 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 month, 66.8% (125/187) of people attending general practice with influenza-like illness who were tested have then tested positive for a respiratory pathogen.
- In the last month, influenza (37.6%; 47/125) was the most commonly detected pathogen, followed by rhinovirus (35.2%; 44/125) and RSV (8.8%; 11/125) (Figure 13).
- In the year to date, 66.8% (2,002/2,999) 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%; 666/2,002) has been the most commonly detected pathogen, followed by influenza (30.8%; 617/2,002), RSV (8.9%; 179/2,002), SARS-CoV-2 (8.0%; 160/2,002), and human metapneumovirus (6.1%; 123/2,002) (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 30 November 2025



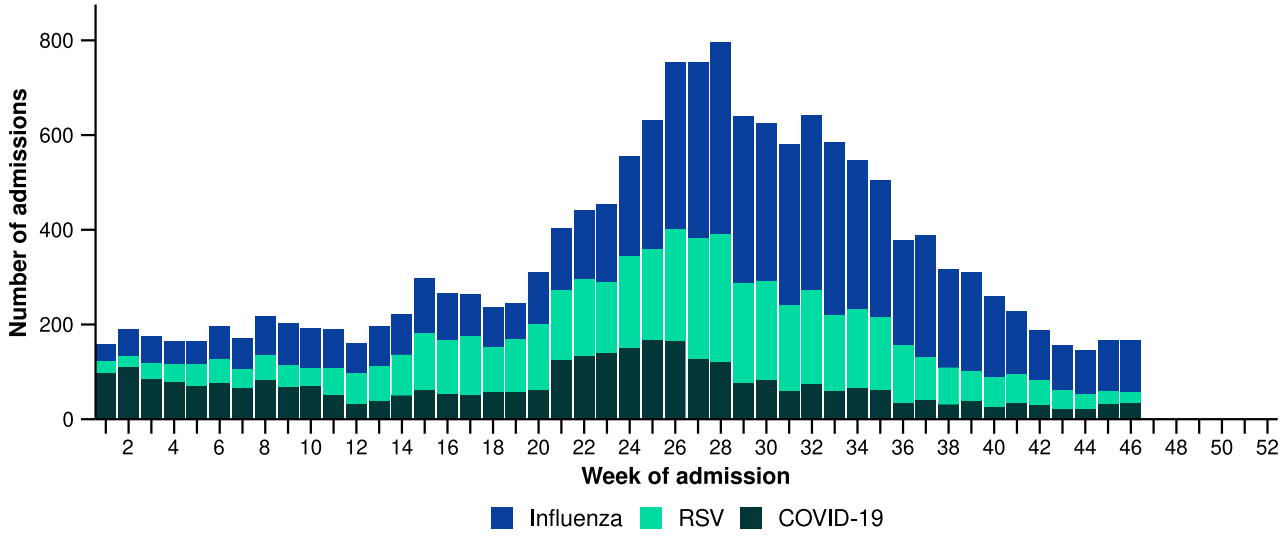
Source: Australian Sentinel Practices Research Network (ASPREN)
Note: All ASPREN swab samples are transported to the SA Pathology laboratory in Adelaide to be tested for viral and bacterial respiratory pathogens via a multiplex real-time reverse transcription polymerase chain reaction (RT-PCR) assay 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 (20 October to 16 November 2025), fewer patients were admitted to a sentinel hospital with a severe acute respiratory infection (n=635), than in the previous severity reporting period (n=986).
  - In the last severity reporting period, at sentinel hospitals there was 16.5% fewer admissions with COVID-19 (from 133 to 111), 34.3% fewer admissions with influenza (from 616 to 405), and 49.8% fewer admissions with RSV (from 237 to 119), compared to the previous severity reporting period.
- In the year to date for severity reporting (1 January to 16 November 2025), there have been 15,836 admissions with severe acute respiratory infections at sentinel hospitals. Most patients with a severe acute respiratory infection have been admitted with influenza (n=7,660) followed by RSV (n=4,881) (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 16 November 2025

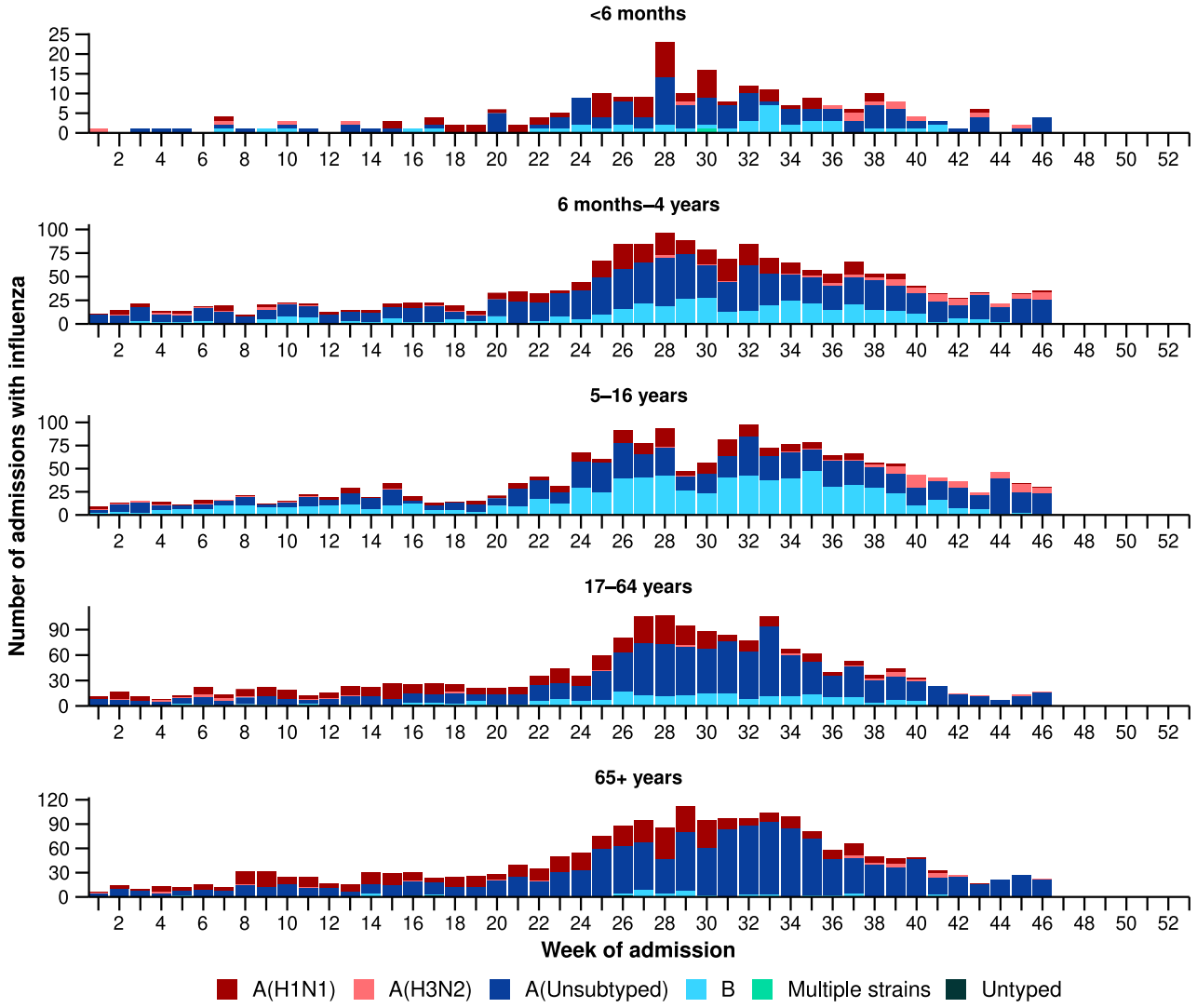


Source: Influenza Complications Alert Network (FluCAN)

- Patients admitted to sentinel hospitals with influenza have mostly been admitted with influenza A (80.8%; 6,189/7,660), while 18.9% (1,444/7,660) were admitted with influenza B.
  - Most hospital admissions with influenza A have been with influenza A(Unsubtyped) (70.3%; 4,352/6,189), followed by influenza A(H1N1) (25.6%; 1,585/6,189) and then influenza A(H3N2) (4.1%; 252/6,189).
- In the year to date for severity reporting, influenza A was the most commonly detected influenza type in all age groups, except among school aged children (5–16 years) where influenza B was more commonly detected. Influenza A(H1N1) has been more common than influenza A(H3N2) across all age groups, though a growing number of admissions with influenza A(H3N2) have been detected in recent weeks (Figure 15).

– 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 16 November 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, more children (those aged 16 years and younger) have been admitted to sentinel hospitals with RSV than with influenza or influenza (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 or COVID-19 had a slightly longer length of hospital stay compared to children with influenza; 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 16 November 2025

	COVID-19 Year to date for severity reporting (n=993)	Influenza Year to date for severity reporting (n=3,872)	RSV Year to date for severity reporting (n=3,874)
Age (years)			
Median [IQR]	1 [0-4]	4 [1-8]	1 [0-2]
Age group (years)			
< 6 months	307 (30.9%)	231 (6.0%)	877 (22.6%)
6 months – 4 years	450 (45.3%)	1,782 (46.0%)	2,698 (69.6%)
5–16 years	234 (23.6%)	1,859 (48.0%)	299 (7.7%)
Indigenous status			
Aboriginal and Torres Strait Islander	89 (9.0%)	271 (7.0%)	279 (7.2%)
Length of hospital stay (days)†			
Median [IQR]	2 [1-3]	1 [1-2]	2 [1-3]
Patient admission location‡			
Admitted to hospital ward	923 (93.0%)	3,666 (94.7%)	3,681 (95.0%)
Admitted to intensive care directly	70 (7.0%)	206 (5.3%)	193 (5.0%)
Discharge status†			
Alive	777 (78.2%)	2,963 (76.5%)	3,217 (83.0%)
Died	1 (0.1%)	6 (0.2%)	2 (0.1%)
Incomplete/missing	215 (21.7%)	903 (23.3%)	655 (16.9%)

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 RSV or COVID-19 (Table 2b).
- Adults admitted to sentinel hospitals with either COVID-19, influenza or RSV tended to be older and predominately aged 65 years or over (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 length was minor. A higher proportion of adults with influenza were admitted directly to an 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 infection who have died in sentinel hospitals (Table 2b).

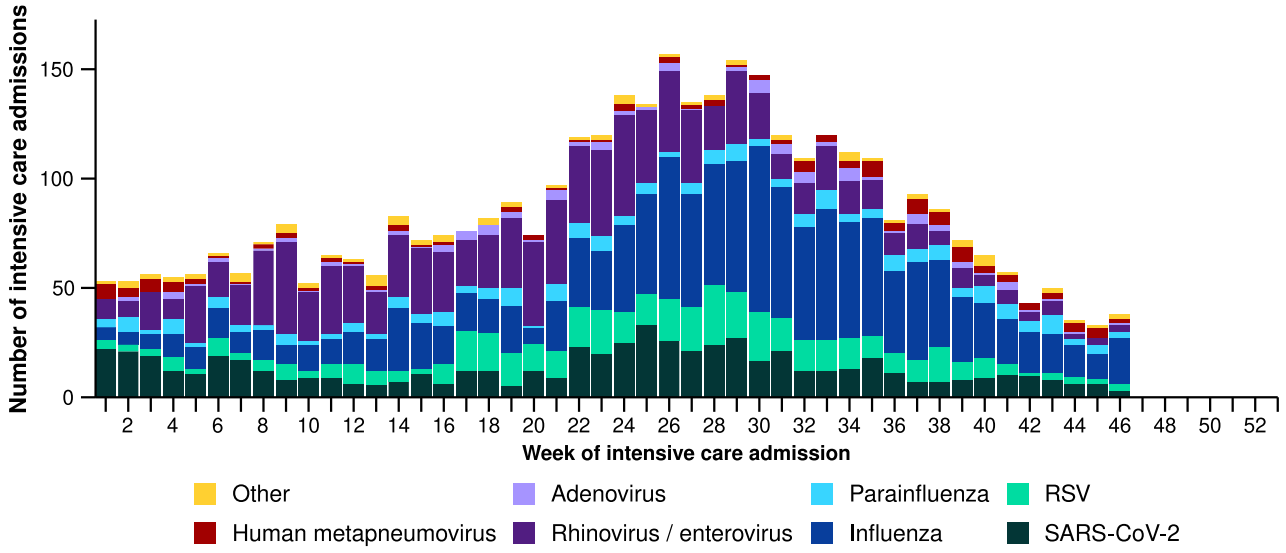
Table 2b: Demographic characteristics and outcomes for adults admitted with a severe acute respiratory infection to a sentinel hospital by disease*†‡, Australia, 1 January to 16 November 2025

	COVID-19 Year to date for severity reporting (n=2,302)	Influenza Year to date for severity reporting (n=3,785)	RSV Year to date for severity reporting (n=1,007)
Age (years)			
Median [IQR]	75 [61-84]	67 [52-78]	73 [59-82]
Age group (years)			
17–64 years	677 (29.4%)	1,740 (46.0%)	330 (32.8%)
65 years and over	1,625 (70.6%)	2,045 (54.0%)	677 (67.2%)
Indigenous status			
Aboriginal and Torres Strait Islander	129 (5.6%)	336 (8.9%)	74 (7.3%)
Length of hospital stay (days)†			
Median [IQR]	5 [2-10]	4 [2-7]	4 [2-8]
Patient admission location‡			
Admitted to hospital ward	2,177 (94.6%)	3,519 (93.0%)	940 (93.3%)
Admitted to intensive care directly	125 (5.4%)	266 (7.0%)	67 (6.7%)
Discharge status†			
Alive	1,844 (80.1%)	3,015 (79.7%)	785 (78.0%)
Died	81 (3.5%)	122 (3.2%)	44 (4.4%)
Incomplete/missing	377 (16.4%)	648 (17.1%)	178 (17.7%)

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.

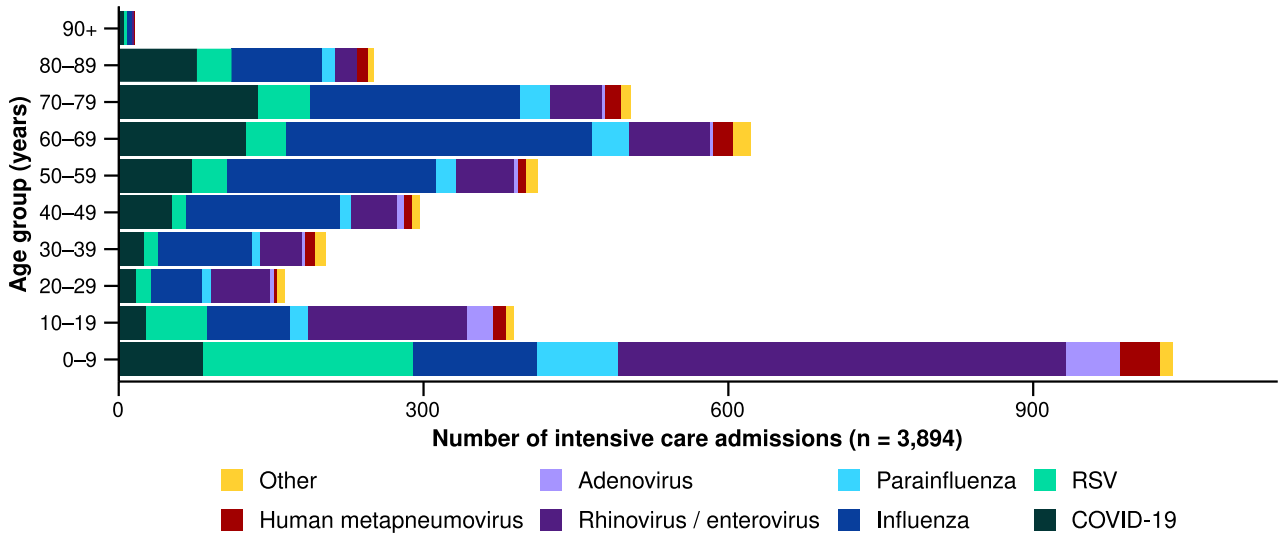
- In the last severity reporting period for sentinel intensive care (20 October to 16 November 2025), fewer patients have been admitted to a sentinel intensive care with a severe acute respiratory infection (n=153), than in the previous severity reporting period (n=223) (Figure 16).
- In the year to date for severity reporting (1 January to 16 November 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 16 November 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 16 November 2025



Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: 5.2% (193/3,688) 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 rhinovirus or RSV have been among younger people, primarily those aged 0–19 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).

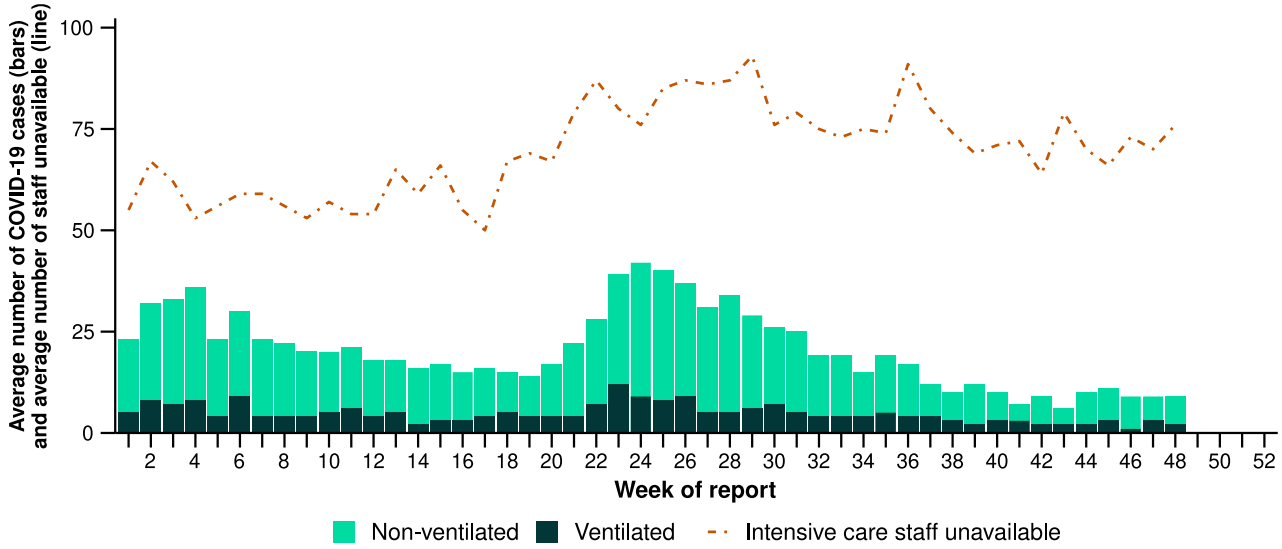
Table 3: Demographic characteristics and outcomes of patients admitted with a severe acute respiratory infection to a sentinel intensive care by disease*†, Australia, 1 January to 16 November 2025

	COVID-19	hMPV	Influenza	Parainfluenza	Rhinovirus	RSV	Other
	Year to date for severity reporting (n=622)	Year to date for severity reporting (n=129)	Year to date for severity reporting (n=1,313)	Year to date for severity reporting (n=224)	Year to date for severity reporting (n=949)	Year to date for severity reporting (n=466)	Year to date for severity reporting (n=191)
Age (years)							
Median [IQR]	63 [40–74]	39 [6–68]	58 [37–69]	38 [6–66]	11 [4–43]	12 [3–62]	18 [6–54]
Indigenous status							
Aboriginal and Torres Strait Islander	57 (9.2%)	6 (4.7%)	108 (8.2%)	18 (8.0%)	88 (9.3%)	35 (7.5%)	21 (11.0%)
Non-Indigenous	565 (90.8%)	123 (95.3%)	1205 (91.8%)	206 (92.0%)	861 (90.7%)	431 (92.5%)	170 (89.0%)
Received invasive mechanical ventilation							
Number (%)	180 (28.9%)	34 (26.4%)	459 (35.0%)	87 (38.8%)	272 (28.7%)	98 (21.0%)	76 (39.8%)
Length of invasive mechanical ventilation (days)*							
Median [IQR]	3 [1–6]	4 [1–8]	6 [2–11]	3 [1–7]	3 [1–7]	3 [1–7]	3 [1–6]
Length of intensive care stay (days)*							
Median [IQR]	3 [2–5]	3 [2–6]	3 [2–7]	3 [2–7]	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]	7 [4–14]	6 [3–12]	6 [3–10]	7 [3–16]
Patient outcome†							
Ongoing care in intensive care	6 (1.0%)	3 (2.3%)	34 (2.6%)	–	10 (1.1%)	6 (1.3%)	3 (1.6%)
Ongoing care in hospital ward	18 (2.9%)	4 (3.1%)	26 (2.0%)	8 (3.6%)	17 (1.8%)	10 (2.1%)	4 (2.1%)
Transfer to other hospital / facility	107 (17.2%)	12 (9.3%)	197 (15.0%)	31 (13.8%)	93 (9.8%)	56 (12.0%)	24 (12.6%)
Discharged home	385 (61.9%)	95 (73.6%)	894 (68.1%)	170 (75.9%)	762 (80.3%)	363 (77.9%)	142 (74.3%)
Died in hospital	101 (16.2%)	14 (10.9%)	156 (11.9%)	14 (6.2%)	62 (6.5%)	30 (6.4%)	17 (8.9%)

Source: Short Period Incidence Study of Severe Acute Respiratory Infection (SPRINT-SARI) Australia
Note: 5.2% (193/3,688) 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 month (3 November to 30 November 2025), there were more COVID-19 cases occupying intensive care beds across Australia than in the previous month (Figure 18).
- In the last month, there were a similar number of intensive care staff unavailable to work due to illness across Australia than in the previous month (Figure 18).

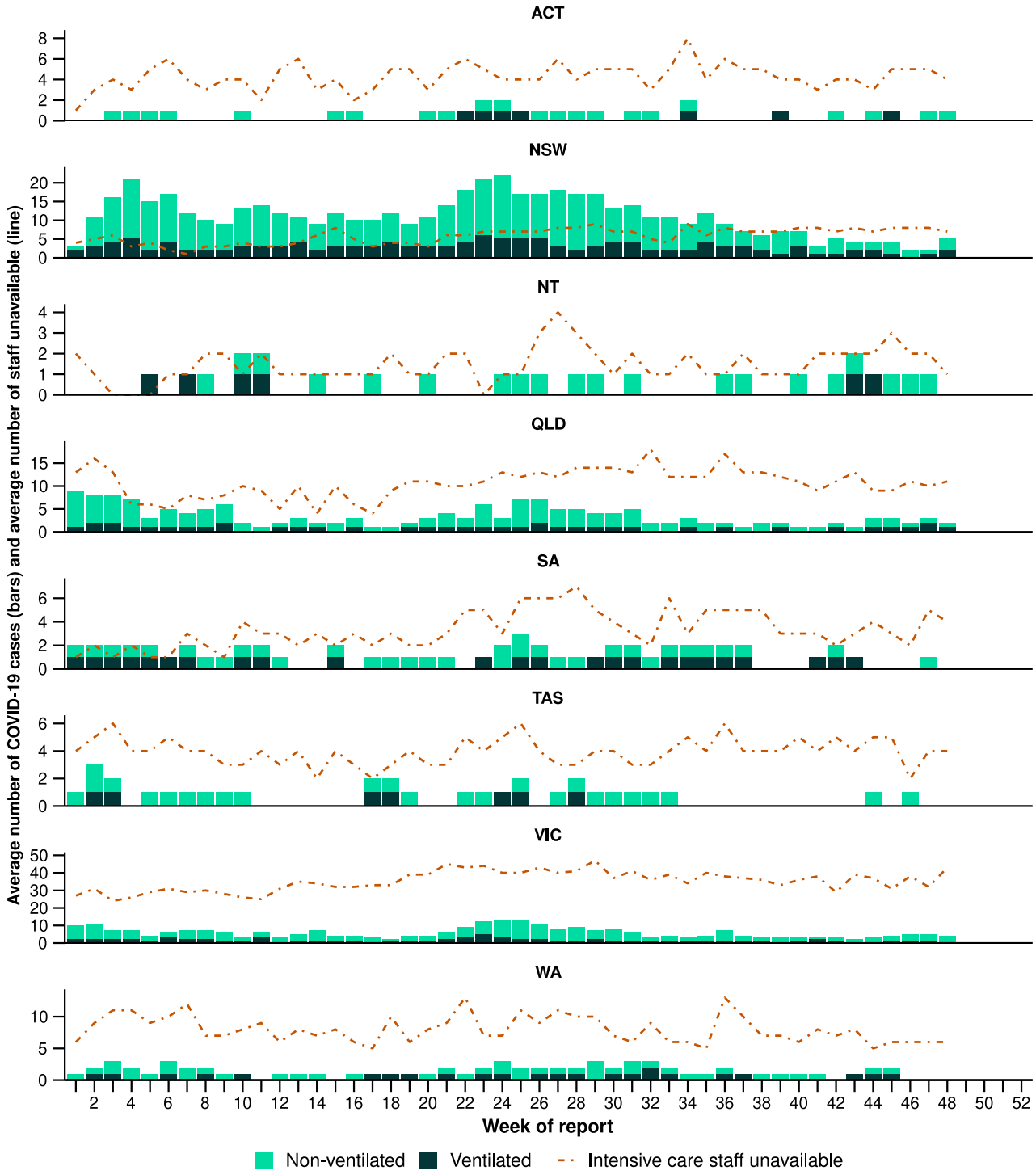
Figure 18: Average number of COVID-19 cases in intensive care and the average number of intensive care staff unavailable to work due to illness by week of report*†, Australia, 1 January to 30 November 2025



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 month, the number of COVID-19 cases occupying intensive care beds decreased or remained stable across most jurisdictions compared to the previous month, except in Vic where COVID-19 cases occupying intensive care beds increased (Figure 19).
- In the last month, the number of intensive care staff unavailable to work due to illness decreased or remained stable across most jurisdictions compared to the previous month, except in the ACT and SA where intensive care staff unavailable to work increased (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 30 November 2025



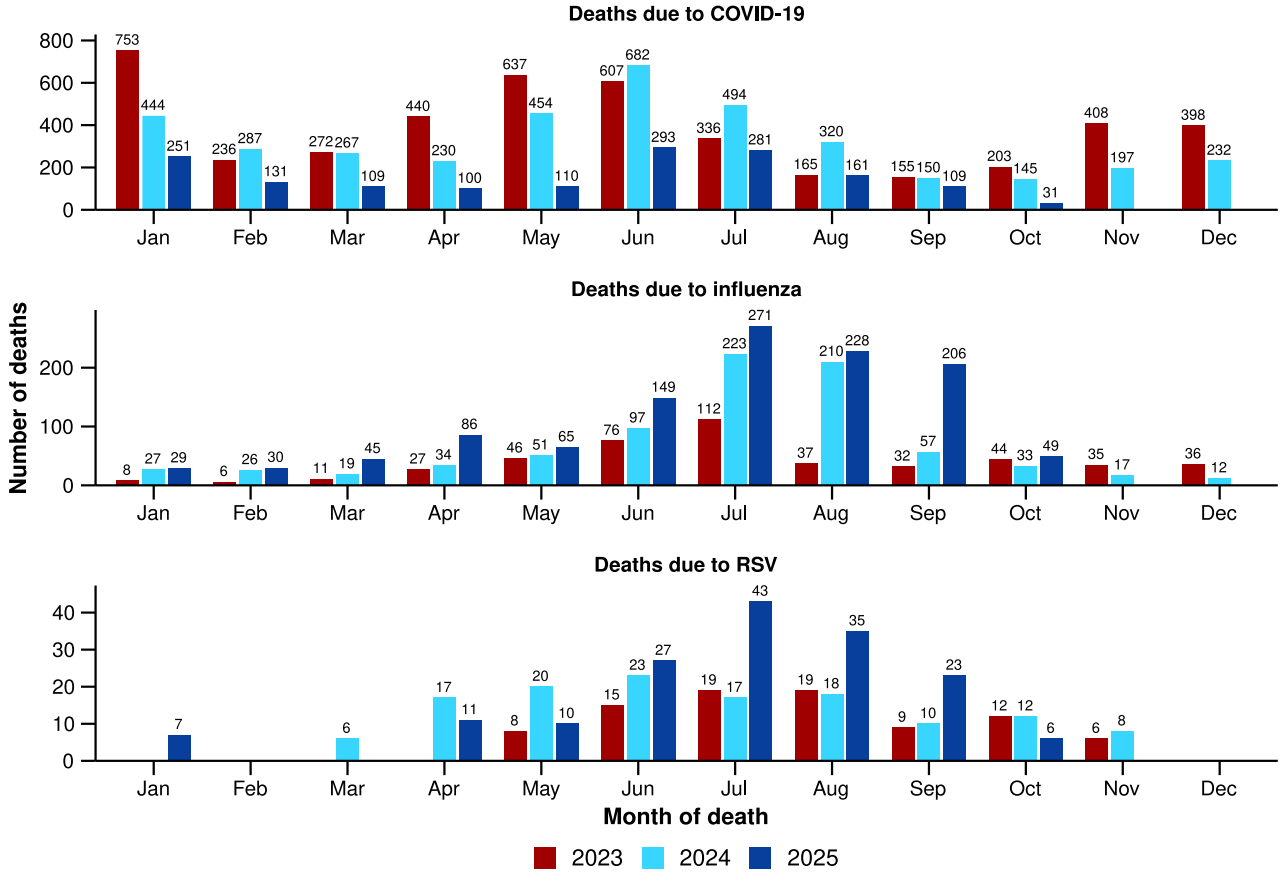
Source: Critical Health Resource Information System (CHRIS)
* Axis varies between jurisdictions.
† Average number of ventilated and non-ventilated COVID-19 cases in intensive care includes only active COVID-19 cases (those in isolation) and does not include cleared COVID-19 cases.
‡ Intensive care staff 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 detailed definitions of deaths *due to* and *with* acute respiratory infections, refer to the Technical Supplement.

- An acute respiratory associated death is one where the death was directly caused by, or *due to*, the disease (the illness 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 the majority of 2023–2025. In August and September 2025, the number of deaths involving influenza (both *due* to and *with*) have exceeded the number of deaths involving COVID-19.
- Deaths involving (both *due* to and *with*) COVID-19 were higher than deaths involving influenza or RSV among Aboriginal and Torres Strait Islander people for each year in 2022–2024. In 2025 to date, there have been more deaths involving influenza among Aboriginal and Torres Strait Islander people.
- 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. There were more deaths in June and July 2025 than earlier in the year, but the winter peak has been much smaller than in 2023 or 2024 (Figure 20a/b).

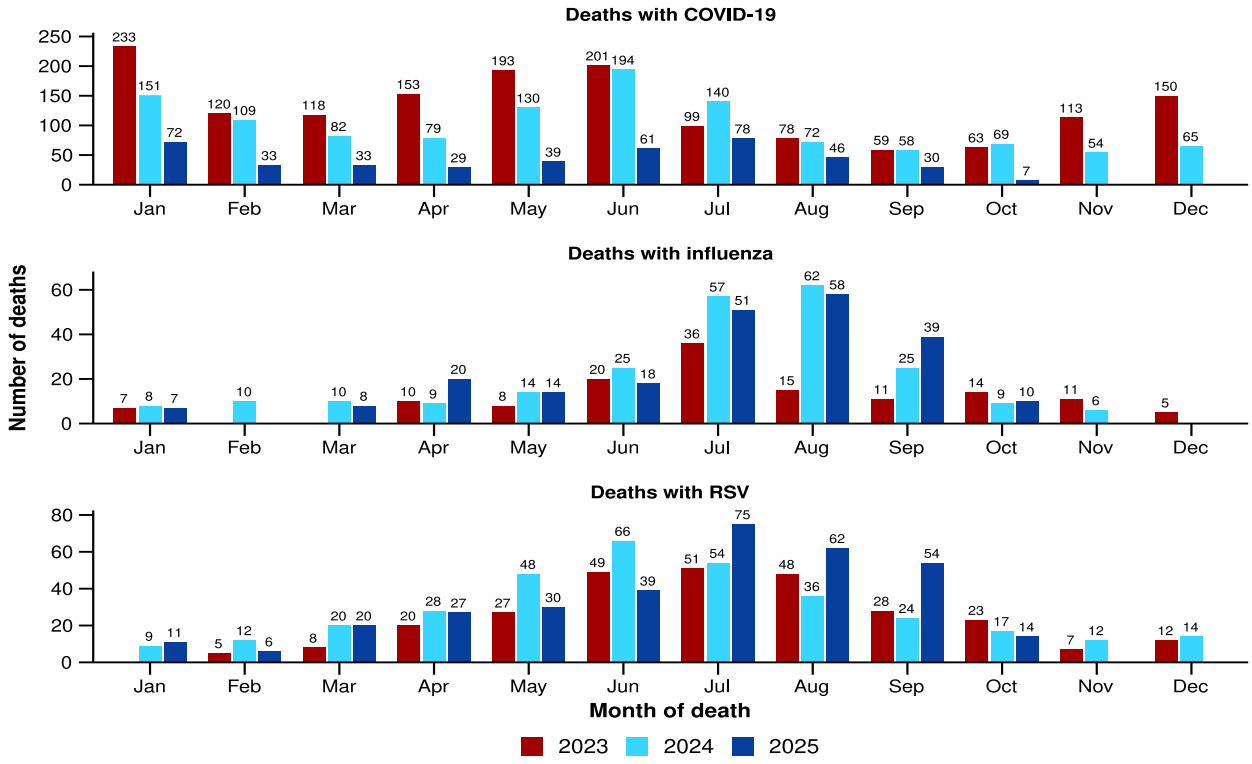
Figure 20a: Provisional numbers of deaths *due to* an acute respiratory infection*† by month, year, and disease, Australia, 1 January 2023 to 31 October 2025



Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia, released 28 November 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 October 2025.

- Deaths *due to* COVID-19 fell in September 2025 to be comparable to the low levels recorded in the autumn months of 2025. Deaths *due to* COVID-19 remain at lower levels than the same period in earlier years (Figure 20a).
- Deaths *due to* influenza decreased slightly in September 2025 and remain higher than the number of deaths *due to* COVID-19. There were 1,109 deaths *due to* influenza in the first nine months of 2025, slightly more than the 1,076 deaths recorded in the first nine months of 2017 and 981 deaths recorded in the first nine months of 2019, which were recent bad years for influenza (Figure 20a). As noted previously, however, there was also a higher number of influenza cases notified in this period than in previous years.
- Deaths *due to* RSV decreased in September but remain higher than September 2023 and 2024 (Figure 20a).
- Deaths *with* COVID-19 decreased in September 2025 and remain lower than in previous years (Figure 20b).
- Deaths *with* influenza decreased in September 2025 but are higher than in September 2024 (Figure 20b).
- Deaths *with* RSV decreased in September 2025 but is higher than in September 2023 and 2024. There were 324 deaths *with* RSV in the first nine months of 2025, higher than the 297 deaths in the first nine months of 2024 and 236 deaths in the first nine months of 2023 (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 October 2025



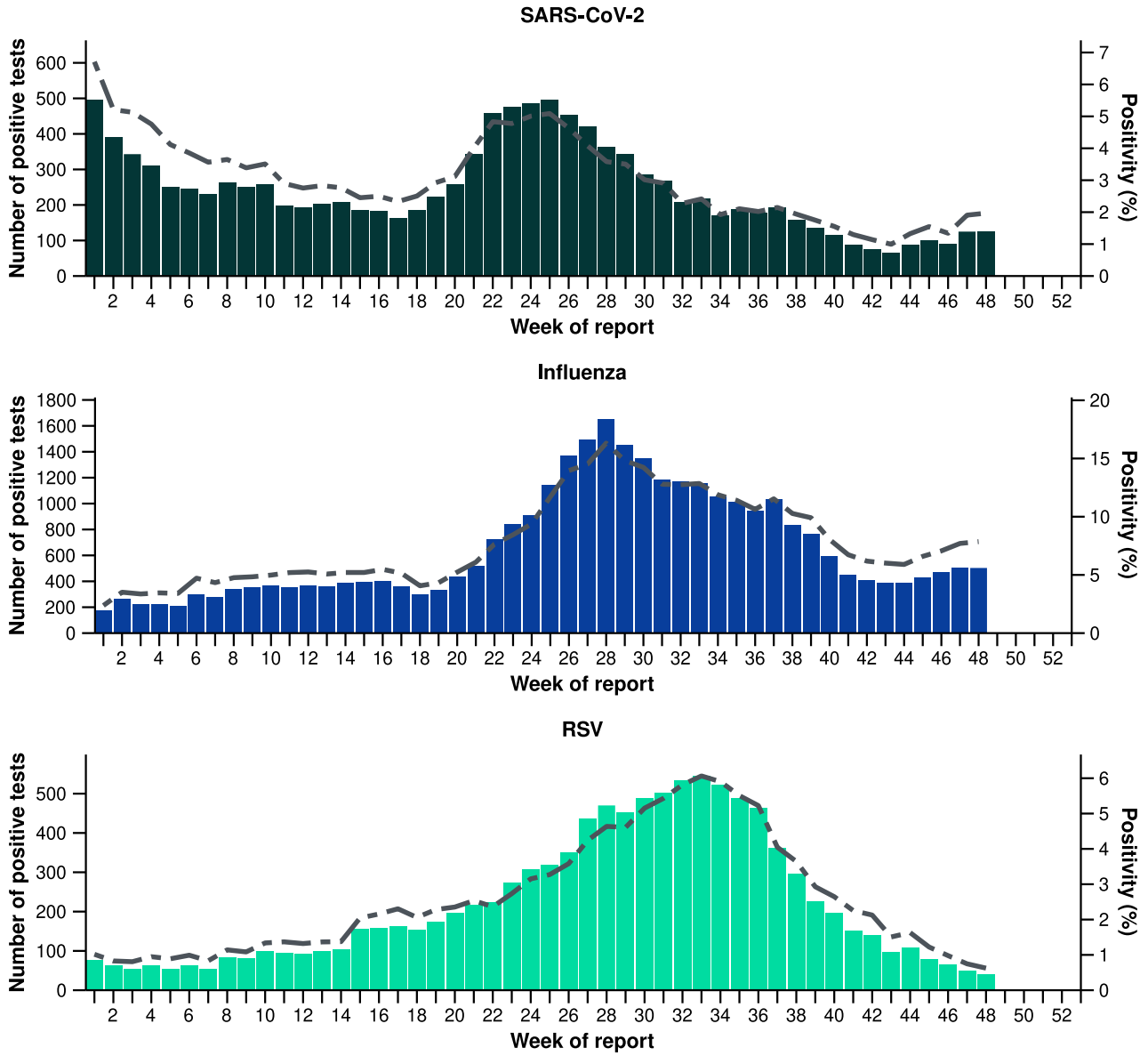
Source: Australian Bureau of Statistics, Deaths due to acute respiratory infections in Australia, released 28 November 2025.
* Axis varies between acute respiratory infections.
† Data is provisional and subject to change. It can take several weeks for death registrations to be reported, processed, coded, 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 October 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 month (3 November to 30 November 2025), SARS-CoV-2 test positivity increased to 1.7% (361/21,351), influenza test positivity increased to 7.3% (1,903/26,055), and RSV test positivity decreased to 0.8% (177/21,351) (Figure 21).

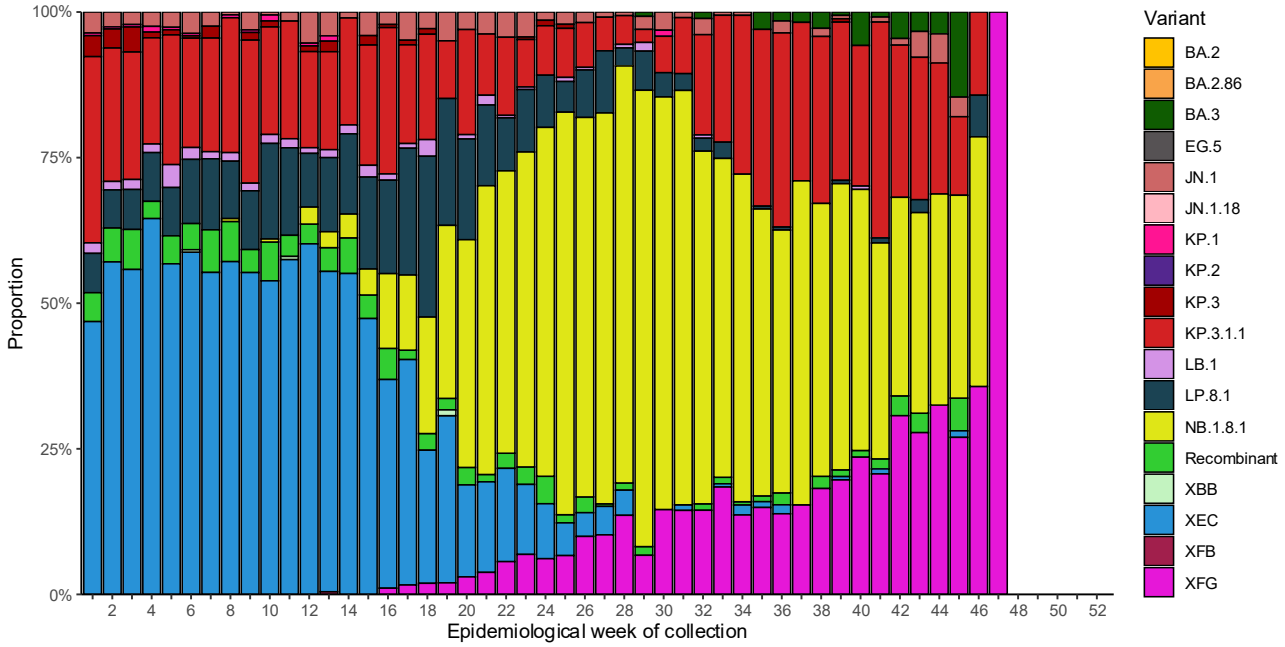
Figure 21: Number of tests positive (bars) and test positivity (line) for SARS-CoV-2, influenza or RSV of those specimens tested by sentinel laboratories by week of report*†, Australia, 1 January to 30 November 2025



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 104 SARS-CoV-2 sequences uploaded to AusTrakka with dates of collection in the last 28 days (3 November to 30 November 2025). These sequences were from NSW, Qld, SA and WA, with the most recent collection date 17 November 2025. The low number of sequences uploaded to AusTrakka in the last 28 days is likely due to the reduced number of cases and changes in sequencing capacity and priorities.
- 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:
  - 17.3% (18/104) of sequences were from the sub-sub-lineages JN.1 (BA.2.86.1.1), specifically from KP.3.1.1 (14/104). No sequences were identified from KP.2.
  - 70.2% (73/104) of sequences were recombinant or recombinant sub-lineages, including NB.1.8.1 and XFG.
  - 12.5% (13/104) 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 has been the dominant sub-lineage in the last 28 days, accounting for 35.6% (37/104) 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:
  - 586 XFG sequences in AusTrakka, with 30 collected in the last 28 days
  - 2,501 NB.1.8.1 sequences in AusTrakka, with 37 collected in the last 28 days
  - 771 LP.8.1 sequences in AusTrakka, with one collected in the last 28 days
  - 3,632 KP.3.1.1 sequences in AusTrakka, with 14 sequences collected in the last 28 days
  - 3,474 XEC sequences in AusTrakka, with one 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 30 November 202



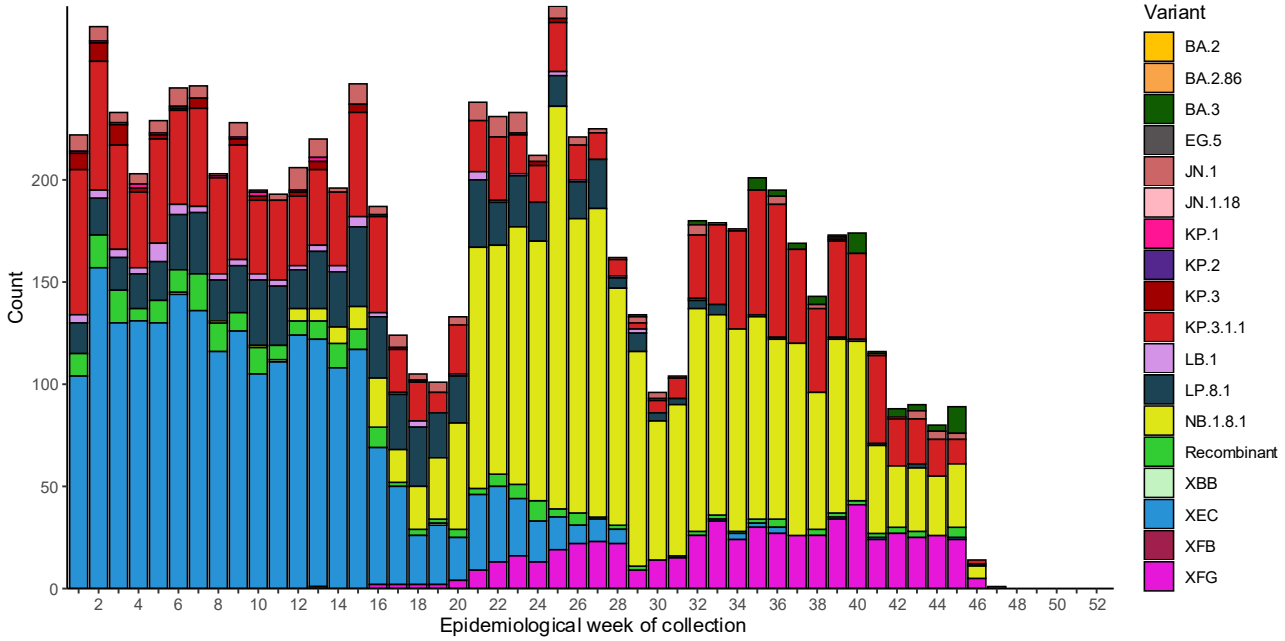
Source: AusTrakka

* 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 30 November 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 4,590 influenza viruses from Australia (Table 4), of which:
  - 67.1% (3,080/4,590) have been influenza A(H1N1)
  - 15.6% (717/4,590) have been influenza A(H3N2)
  - 17.3% (793/4,590) 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, 2.1% (30/1,408) demonstrated highly reduced inhibition to Oseltamivir. None of the influenza A(H3N2) samples tested 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 30 November 2025

Strain	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
A(H1N1)	305	466	699	158	101	444	837	70	**3,080**
A(H3N2)	30	132	251	42	17	57	161	27	**717**
B/Victoria lineage	94	184	105	25	21	53	273	38	**793**
B/Yamagata lineage	0	0	0	0	0	0	0	0	**0**
Total	**429**	**782**	**1,055**	**225**	**139**	**554**	**1,271**	**135**	**4,590**

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, 4.8% 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 (10.9%; Table 5), compared to the 12 months prior (13% from 27 November 2023 to 24 November 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 32% in the 12 months prior to 26.4% in the last 12 months).
- There has been substantial variation in COVID-19 vaccine coverage across age groups, ranging from 4.5% in adults aged 18–64 years to 41.7% in adults aged 75 years and over. Vaccine coverage increases with increasing age (Table 5).
- There has been some variation in vaccine coverage across jurisdictions, ranging from 4.2% in the NT to 18.8% in Tas (Table 5).

Table 5: COVID-19 vaccine coverage*†‡ by age group and jurisdiction, Australia, 25 November 2024 to 30 November 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Last 12 months (25 November 2024 to 30 November 2025)									
18–64 years	10.1	3.9	2.1	4.3	4.5	8.3	4.9	4.5	4.5
65–74 years	47.8	24.5	15.2	25.4	27.4	39.2	26.8	26.9	26.4
≥ 75 years	65.0	39.6	26.3	40.6	41.8	56.2	41.0	43.3	41.7
All ages (18 years and over)	18.1	10.1	4.2	10.5	12.0	18.8	10.9	10.6	10.9
Last 6 months (26 May 2025 to 30 November 2025)									
18–64 years	4.0	1.7	1.1	2.0	2.0	3.4	2.1	2.1	2.0
65–74 years	18.1	10.0	7.9	11.1	11.2	14.9	10.7	11.4	10.9
≥ 75 years	29.7	18.1	13.1	19.4	19.3	24.6	18.4	20.0	19.2
All ages (18 years and over)	7.5	4.4	2.2	4.8	5.3	7.7	4.7	4.8	4.8

Source: Australian Immunisation Register (AIR) as at 1 December 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, 2.1% 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 (4.6%; Table 6), compared to the 12 months prior (6.1% from 27 November 2023 to 24 November 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 33% in the 12 months prior to 27.2% in the last 12 months).
- Among Aboriginal and Torres Strait Islander people there has been substantial variation in COVID-19 vaccine coverage across age groups, ranging from 2.6% in adults aged 18–64 years to 27.2% in adults aged 75 years and over. Vaccine coverage increases with increasing age (Table 6).
- Among Aboriginal and Torres Strait Islander people, there has been slight variation in vaccine coverage across jurisdictions, ranging from 2.7% in the NT to 9.6% in Tas (Table 6).

Table 6: COVID-19 vaccine coverage*†‡ among Aboriginal and Torres Strait Islander populations by age group and jurisdiction, Australia, 25 November 2024 to 30 November 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Last 12 months (25 November 2024 to 30 November 2025)									
18–64 years	5.9	2.6	1.9	2.4	2.7	5.4	3.8	2.2	2.6
65–74 years	33.8	18.7	9.7	17.1	17.0	31.5	20.1	16.2	17.6
≥ 75 years	48.4	29.0	13.8	25.4	29.2	43.5	32.9	26.3	27.2
All ages (18 years and over)	9.1	5.0	2.7	4.2	4.7	9.6	6.5	3.8	4.6
Last 6 months (26 May 2025 to 30 November 2025)									
18–64 years	2.1	1.2	1.1	1.1	1.3	2.3	1.6	1.1	1.2
65–74 years	13.8	8.0	5.1	7.7	7.5	11.7	7.9	7.5	7.6
≥ 75 years	21.7	13.4	6.6	12.4	13.5	18.5	15.1	12.9	12.7
All ages (18 years and over)	3.5	2.3	1.5	2.0	2.2	3.9	2.8	1.9	2.1

Source: Australian Immunisation Register (AIR) as at 1 December 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.
- From November, temporarily the influenza vaccine coverage data will not be updated in line with the current reporting period. However, historical updates may still be made to data from the seasonal influenza vaccine campaign. As a result, coverage metrics could differ between this report and previous reports.
- Nationally, influenza vaccine coverage is 30.7% for the 2025 season (Table 7).
- There has been substantial variation in influenza vaccine coverage across age groups, ranging from 14.7% in children aged 5–14 years to 61.5% 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 has been some variation in influenza vaccine coverage across jurisdictions, ranging from 26.1% in the NT to 40.2% in the ACT (Table 7).
- Among Aboriginal and Torres Strait Islander populations, there has been substantial variation in influenza vaccine coverage across age groups, ranging from 11.3% in children aged 5–14 years to 61.6% in adults aged 65 years and over (Table 7).
- Among Aboriginal and Torres Strait Islander populations, there has been some variation in influenza vaccine coverage across jurisdictions, ranging from 20.1% in WA to 35.6% in the NT (Table 7).

Table 7: Influenza vaccine coverage*†‡ by age group and jurisdiction, Australia, 1 March to 2 November 2025

	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Age groups									
6 months to <5 years	54.5	28.9	43.4	23.5	32.7	35.5	35.7	27.2	30.3
5–14 years	24.1	13.6	14.5	13.4	15.6	15.3	16.1	15.5	14.7
15–49 years	32.9	19.7	23.7	18.7	24.0	23.9	24.0	19.1	21.2
50–64 years	44.0	30.3	26.8	31.9	36.4	39.6	34.5	31.1	32.6
≥ 65 years	65.5	59.0	38.4	61.7	67.6	69.0	62.7	60.9	61.5
All ages (6 months and over)	40.2	29.3	26.1	28.7	35.3	36.9	32.8	28.7	30.7
Aboriginal and Torres Strait Islander populations									
6 months to <5 years	35.4	19.7	44.3	16.5	19.8	25.0	24.8	20.6	21.0
5–14 years	0.0	11.2	23.8	10.9	12.7	12.9	0.0	11.8	11.3
15–49 years	26.5	17.3	33.8	16.4	20.4	20.1	19.9	16.3	18.9
50–64 years	0.0	36.9	46.6	35.7	39.0	46.1	37.3	33.6	37.1
≥ 65 years	69.9	63.4	49.2	61.5	64.6	70.9	64.5	55.3	61.6
All ages (6 months and over)	21.8	22.3	35.6	20.5	24.3	27.0	22.8	20.1	22.8

Source: Australian Immunisation Register (AIR) as at 1 December 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, 161,093 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 30 November 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
15–24 years	227	4,057	324	3,729	887	436	2,354	1,561	13,576
25–39 years	3,693	43,389	1,388	25,322	9,676	2,976	38,264	14,117	138,825
40–54 years	244	2,869	69	1,315	550	124	2,675	846	8,692
Total (15–54 years)	4,164	50,315	1,781	30,366	11,113	3,536	43,293	16,524	161,093

Source: Australian Immunisation Register (AIR) as at 1 December 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, 11.5% of infants (aged < 8 months) have received nirsevimab (Table 9).
- There has been some variation in nirsevimab uptake in infants across jurisdictions, ranging from 4.2% in the ACT to 18.4% in Tas (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, 26 May 2025 to 30 November 2025

Age group	ACT	NSW	NT	Qld	SA	Tas	Vic	WA	Total
Infants (aged < 8 months)	4.2	7.6	12.5	11.3	13.5	18.4	13.5	17.0	11.5
Young children (aged ≥ 8 to 24 months)	0.2	0.2	0.2	0.1	0.5	0.9	0.7	1.2	0.5

Source: Australian Immunisation Register (AIR) as at 1 December 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 - interim estimates

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

- Vaccine effectiveness (VE) is the reduction in risk of influenza and its complications in those vaccinated, compared to those not vaccinated. Interim Australian studies suggest that in 2025, vaccinated people are roughly 53% less likely to attend general practice or be hospitalised with influenza than unvaccinated people. Please note, these interim estimates are based on incomplete data and the final VE estimates for 2025 may differ.
- Estimated VE against general practice attendance with influenza overall is 56% (95% Confidence Interval [CI]: 40%, 68%).
  - Estimated VE against general practice attendance with influenza A(H1N1) is 51% (95% CI: 26%, 67%). No estimates are available for VE against general practice attendance with influenza A(H3N2) due to low case numbers.
  - Estimated VE against general practice attendance with influenza B is 60% (95% CI: 27%, 78%).
  - Estimated VE 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 VE estimates against general practice attendance for influenza are slightly lower than observed in 2024 (62% overall, 95% CI: 45%, 74%). VE 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, VE 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%, 88%).
- Estimated VE against hospitalisation with influenza overall is 49% (95% CI: 42%, 56%).
  - Estimated VE against hospitalisation with influenza A(H1N1) is 42% (95% CI: 29%, 52%), and for influenza A(H3N2) is 60% (95% CI: 4%, 84%).
  - Estimated VE against hospitalisation with influenza B is 78% (95% CI: 68%, 85%).
  - Estimated VE 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 VE estimates against hospitalisation with influenza are lower when compared to 2024 estimates (56% overall, 95% CI: 48%, 63%). VE in the 18–64 years and 65 years and over age groups are significantly lower compared to 2024 (60%, 95% CI: 35%, 77%, and 81%, 95% CI: 50%, 93% respectively) but remain consistent in children less than 18 years.

Vaccine match

- Refer to the Technical Supplement for information on the 2025 southern hemisphere influenza vaccines composition.
- In the year to date, 99.4% (3,063/3,080) of influenza A(H1N1) isolates, 49.9% (358/717) of influenza A(H3N2) isolates and 98.1% (778/793) of influenza B/Victoria lineage isolates characterised have been antigenically similar to the corresponding 2025 vaccine components.
- Since October, there has been a notable increase in influenza A(H3N2) viruses received by the WHO Collaborating Centre for Reference and Research on Influenza. Antigenic testing of these viruses has shown reduced reactivity to the southern hemisphere 2025 vaccine strain; however, these viruses show reasonable reactivity to the new southern hemisphere 2026 vaccine strain. Further genetic and antigenic analysis is required to understand this change.