



# Australian Government

## Department of Health

# AUSTRALIAN INFLUENZA SURVEILLANCE REPORT

No. 6, 2019  
1 to 14 July 2019

The Department of Health acknowledges the providers of the many sources of data used in this report and greatly appreciates their contribution.

## KEY MESSAGES

- **Activity** – Currently, influenza and influenza-like illness (ILI) activity are above average for this time of year compared to previous years. However, this activity is not unusual when compared to the range of activity during an average influenza season. At the national level, notifications of laboratory-confirmed influenza have decreased in the past fortnight; however, this may be due in some measure to data entry backlogs.
- **Severity** – Clinical severity for the season to date, as measured through the proportion of patients admitted directly to ICU, and deaths attributed to influenza, is low.
- **Virology** – The majority of confirmed influenza cases reported nationally were influenza A in the year to date (83%) and past fortnight (77%). The proportion of influenza B nationally has been increasing each week since early May, however, the proportion has declined in the past week.

## Introduction

Each year, the influenza virus changes and different strains can circulate in the population. Particular subtypes of influenza can affect different groups of the population more than others. Depending on the susceptibility of the population, the subtypes that are circulating and the changes to the virus itself, the influenza season can be very different year to year. Our surveillance systems help us to understand influenza activity, severity of the infection in individuals and impact of the illness on society in Australia. We are also able to monitor which influenza viruses are circulating, which populations might be more affected, the effectiveness of the vaccine, and any resistance to antiviral drugs that has developed.

## 1. Activity

*Activity measures the capacity of the circulating influenza viruses to spread person to person and may be measured indirectly through systems that monitor influenza-like illness and more directly through systems that monitor laboratory confirmed influenza.*

### Influenza-like illness

Following high levels of ILI activity over the interseasonal period, ILI in the community is currently high for this time of year and above the historical range for the same period over the past 5 years. However, activity is within the expected range when compared to months when influenza activity has historically occurred.

- **Healthdirect:** In the year to date, the proportion of calls to the Healthdirect public health hotline related to ILI have been increasing steadily from 3.6% in week 1, to a high of 12.5% and 12.4% in weeks 27 and 28 respectively (Figure 1).
- **Sentinel General Practitioners (ASPREN):** 12.5 per 1,000 consultations in sentinel general practices were due to ILI in week 28 (Figure 2), increasing from 12.0 per 1,000 consultations in week 27. ILI consultations are slightly higher than the 5 year average for this time of year; however, this gap has been decreasing since week 24, after a peak in ILI of 13.5 per 1,000 consultations in week 23.
- **Flutracking:** Since reporting began in week 16, Flutracking participants reporting ILI (fever and cough) has increased from 1.7% to 2.6% in week 27, and reduced slightly in week 28 to 2.2%. Activity in the past fortnight is within the range of activity in the previous five years (Figure 3). For this report onwards, reporting of Flutracking data will now be age standardised.

### Confirmed influenza

Influenza is above average levels and is a major cause of ILI this fortnight in some jurisdictions.

- **Proportion of ILI with confirmed influenza seen by sentinel GPs:** Of the 220 ILI cases presenting to sentinel ASPREN GPs this fortnight who were tested for influenza, 90 (40.9%) had a positive result. This is an increase from the previous fortnight when 38.1% (102/268) of swabbed ILI patients tested positive for

influenza, noting that there is a lag in data entry for week 28. Positive results for patients tested for influenza have continued to increase since a slight drop in week 18. In weeks 1 to 13, all influenza positive cases were influenza A. From week 14 onwards, the proportion of influenza cases testing positive for influenza B has increased steadily to 29% in week 24, dropping slightly to 21% in week 28.

- **Proportion of ILI with confirmed influenza in sentinel labs:** In the year to date, overall detections of influenza across sentinel laboratories decreased to 20.2% in week 28 (unweighted percentage of tests positive for influenza across all sentinel laboratories) after a peak in week 16 of 26.9%. In the past fortnight, positivity has been highest in Victoria (VIC) (Figure 4), which is consistent with an increase in notifications of laboratory-confirmed influenza from this state.

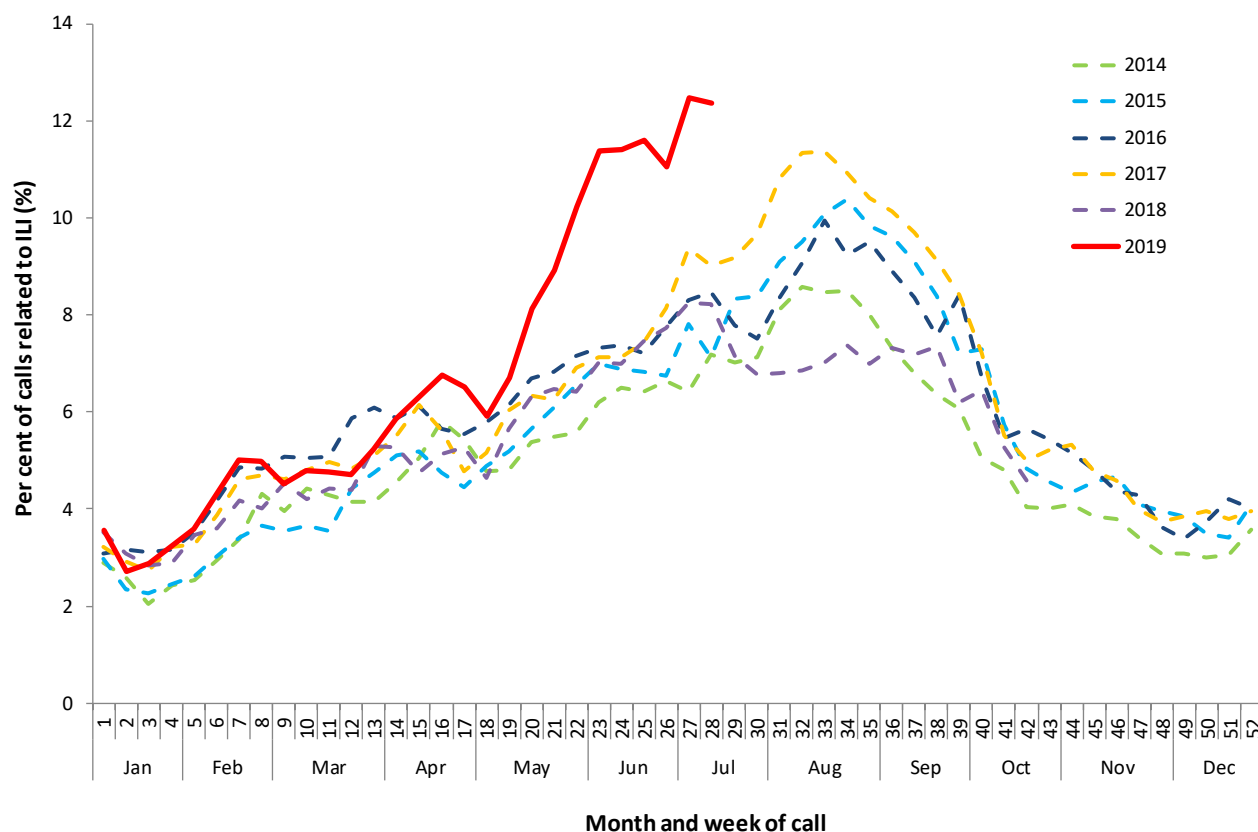
The most commonly detected respiratory viruses this fortnight by laboratory site were:

- influenza A in both weeks 27 and 28 by the Institute of Clinical Pathology and Medical Research in New South Wales (NSW);
- rhinovirus in both weeks by South Australia (SA);
- influenza A in both weeks by the Victorian Infectious Diseases Reference Laboratory (VIDRL);
- influenza A(H3N2) in both weeks by PathWest in Western Australia (WA); and
- rhinovirus in week 27 and influenza A in week 28 by Tasmania (TAS).
- **NNDSS notifications<sup>1</sup>:** In the year to date, there have been 153,272 notifications of laboratory-confirmed influenza to the National Notifiable Diseases Surveillance System (NNDSS). This fortnight there were 26,807 notifications of laboratory-confirmed influenza to the NNDSS. This is a slight decrease in reported cases compared to the previous fortnight (n=27,996). Notifications this fortnight were higher compared to this period in the previous five years (Figure 5). Notifications increased slightly in week 27 and whilst it appears that the number of cases has dropped in the past week, this is at least partly due to a backlog in data entry in some states and territories.
- **FluCAN:** Since seasonal sentinel hospital surveillance began on 1 April 2019, a total of 1,832 people have been admitted with confirmed influenza (Figure 6). In the fortnight to 14 July 2019, 218 people have been admitted with confirmed influenza. This is a decrease from the 345 reported in the previous fortnight, however, it is likely that this is a result of an administrative backlog and that numbers will be revised upwards. This is still greater than the 5-year average for the same fortnight (n=126.2). However, the number of admissions is not abnormal when compared to data during a typical influenza season (activity from late June to October).

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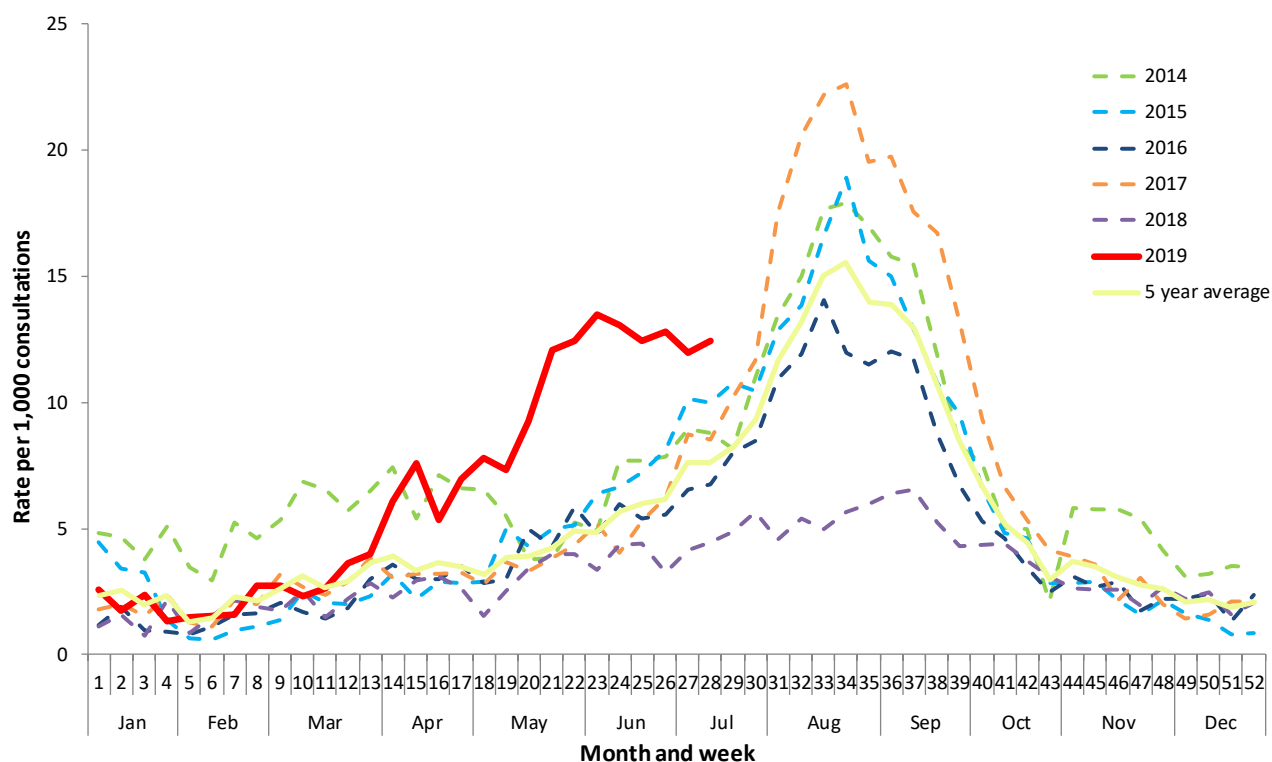
<sup>1</sup>NNDSS notification data provided for the current and most recent weeks may be incomplete. All data are preliminary and subject to change as updates are received.

**Figure 1. Per cent of calls to Healthdirect related to ILI, Australia, 1 January 2014 to 14 July 2019, by month and week of call.**



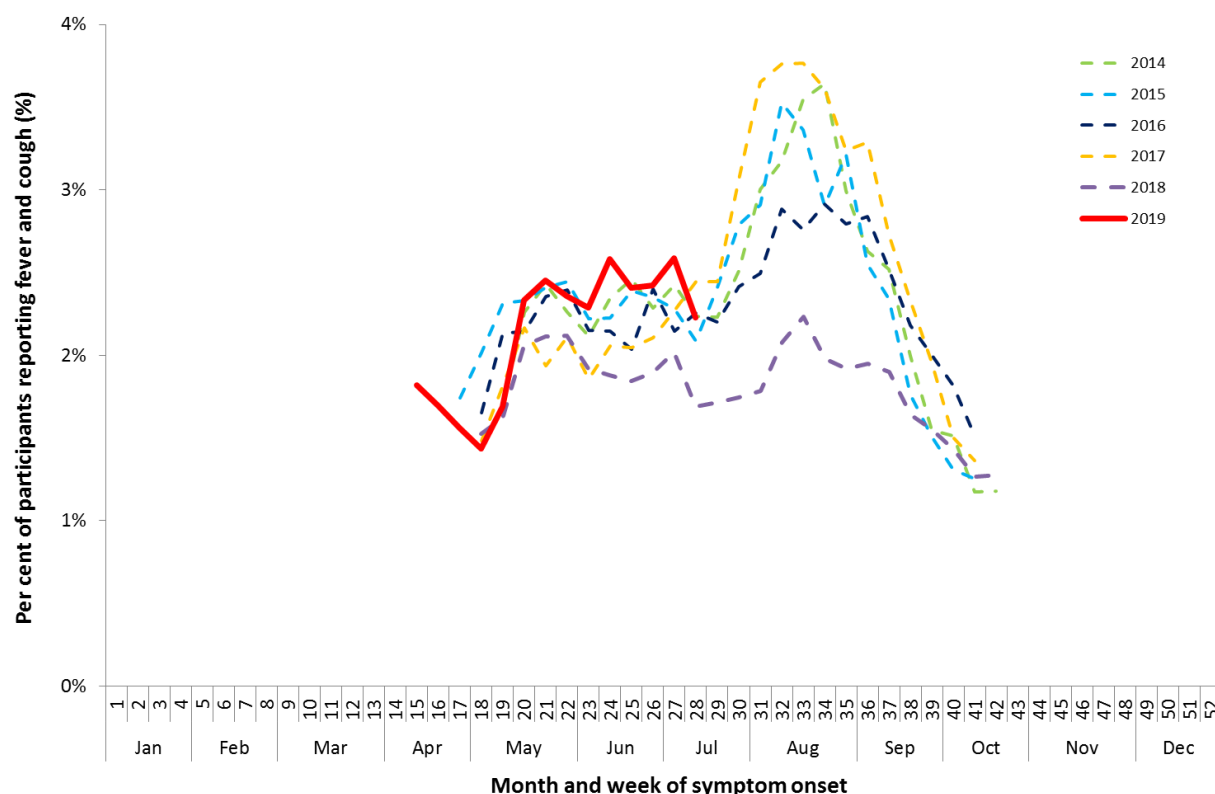
Source: Healthdirect

**Figure 2. Unweighted rate of ILI reported from sentinel GP surveillance systems, Australia, 1 January 2014 to 14 July 2019, by month and week.**



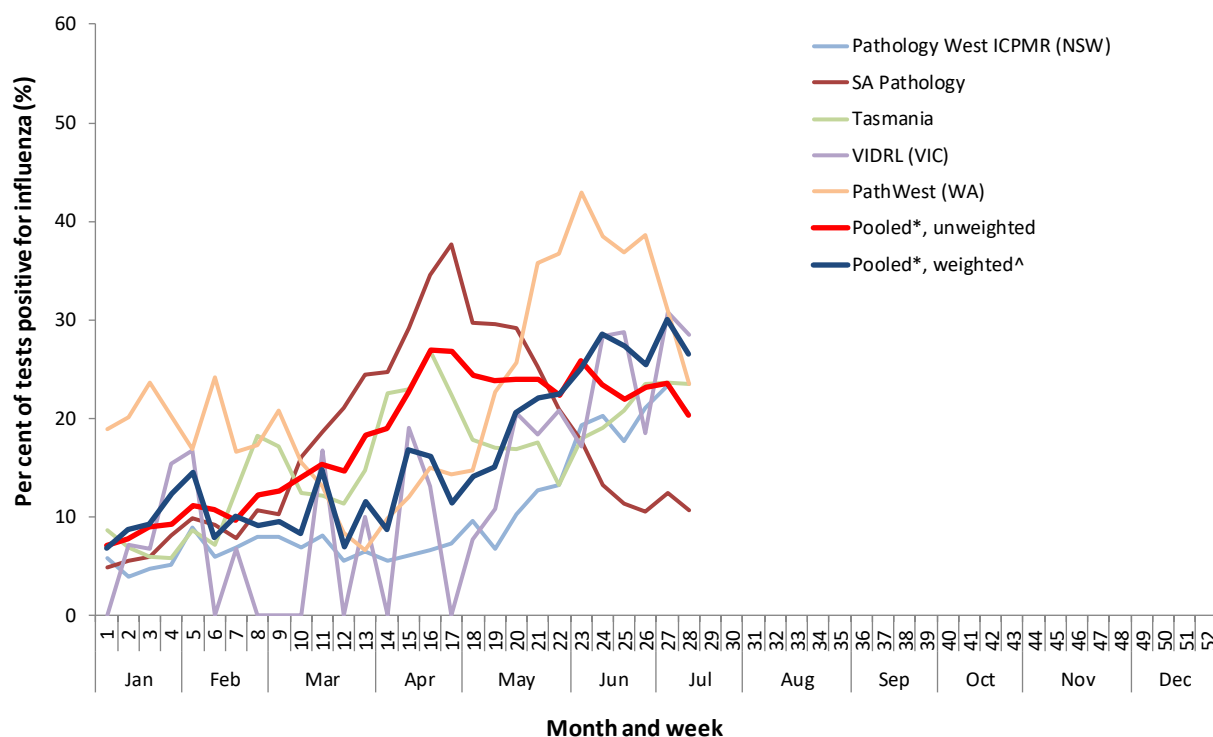
Source: ASPREN

**Figure 3. Proportion of fever and cough among FluTracking participants, Australia, between April and October, 2014 to 2019, by month and week.**



Source: FluTracking

**Figure 4. Proportion of sentinel laboratory tests positive for influenza, 1 January to 14 July 2019, by contributing laboratory or jurisdiction and month and week.**

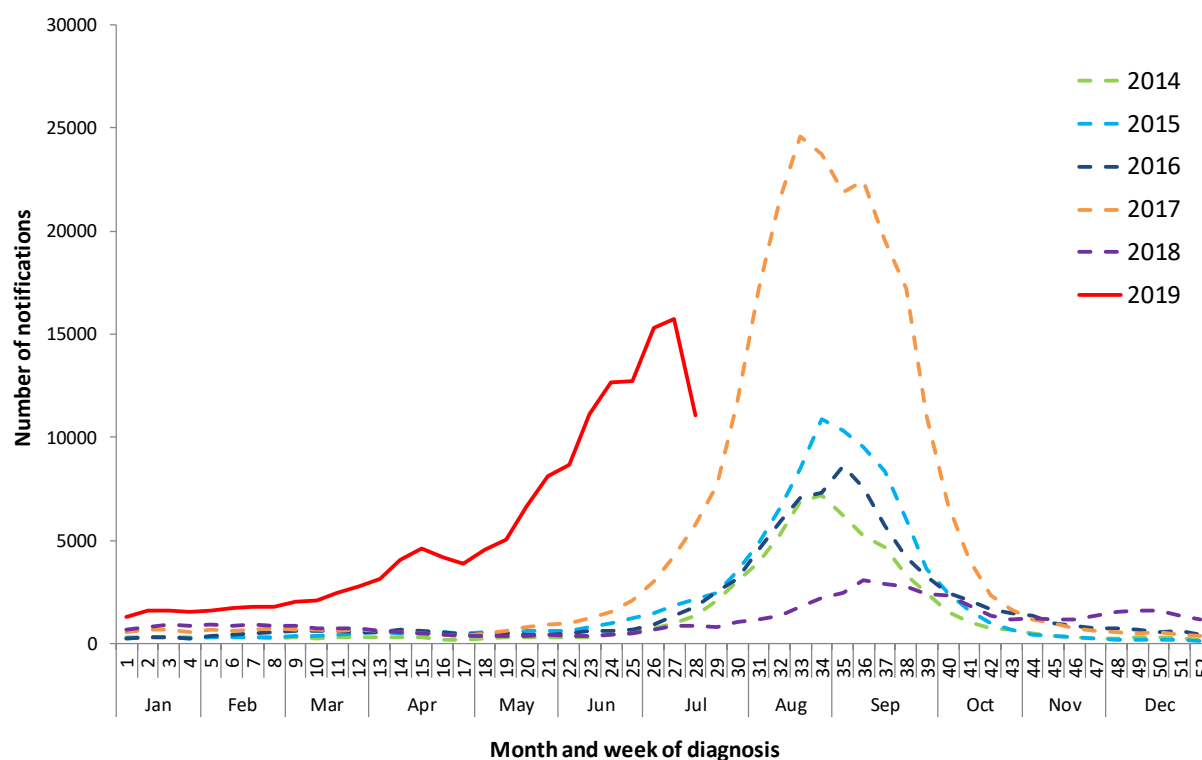


\* Pooled percentage positive indicators should be interpreted with caution, noting that collectively pooled contributing laboratories are not representative of testing across Australia and individually contributing laboratories may not be representative of the jurisdiction in which they are located.

^ Weighted according to jurisdictional population in which laboratories are located.

The percentage of tests positive for influenza in the interseasonal period should be interpreted with caution due to small numbers of tests being undertaken in this time, resulting in high variability in the indicators.

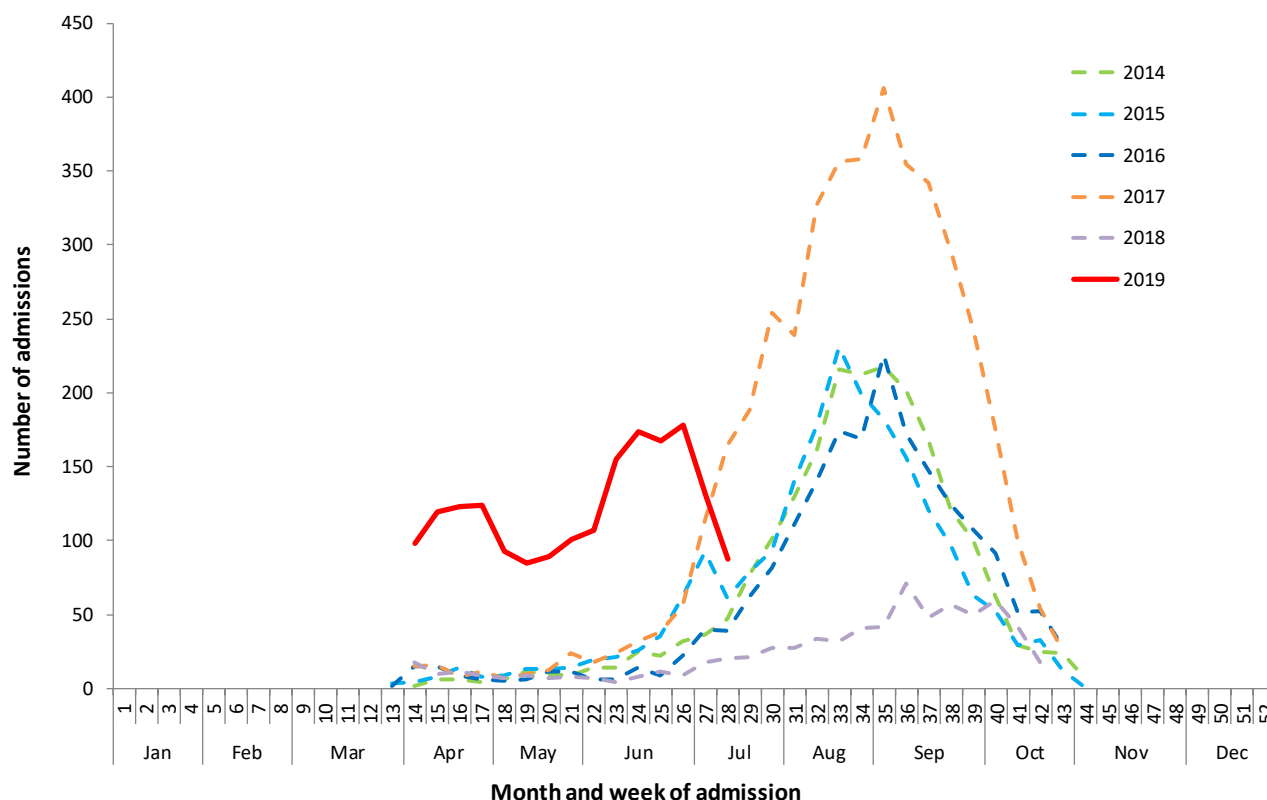
**Figure 5. Notifications of laboratory confirmed influenza, Australia, 1 January 2013 to 14 July 2019, by month and week of diagnosis.\***



Source: NNDSS

\*NNDSS notification data provided for the current and most recent weeks may be incomplete. All data are preliminary and subject to change as updates are received.

**Figure 6. Number of influenza hospitalisations at sentinel hospitals, between March and October, 2014 to 2019 by month and week.\***



Source: FluCAN

\*FluCAN data provided for the current fortnight may be incomplete. All data are preliminary and subject to change as updates are received.

### Geographical distribution of activity

- **Jurisdictional reports:** In the fortnight ending 14 July 2019, the geographic spread of influenza activity was reported by state and territory health departments as being:

- Widespread - SA, Perth and the Southern region of WA, NSW, the Australian Capital Territory (ACT), the Southern region of Queensland (QLD), TAS and Victoria (VIC).
- Regional - North West region of WA and Central QLD.
- Localised – Northern Territory (NT) and Tropical region of QLD (Figure 7).

The change in activity level was reported by state and territory health departments as being:

- Increased - ACT, VIC, TAS and the Central region of NT
- Decreased – all regions in WA, NSW.
- No change – SA, the southern region of NT and all regions of QLD.

- **NNDSS:** Of the 26,807 notifications of influenza reported to the NNDSS in the last fortnight, 11,610 were from NSW, 5,128 from VIC, 3,311 from WA, 5,105 from QLD, 890 from SA, 496 from ACT, 195 from TAS and 72 from NT (Figure 8). This is an increase in notifications reported from the previous fortnight for ACT, NSW, NT, QLD, SA, and TAS.

Of the 153,272 notifications of influenza reported to the NNDSS this year to 14 July 2019, 49,470 were from NSW, 33,028 from VIC, 26,436 from QLD, 20,528 from SA, 19,329 from WA, 1,853 from ACT, 1,591 from TAS and 1,037 from NT.

For further information regarding influenza activity at the jurisdictional level, please refer to the following State and Territory health surveillance reports:

- ACT: ACT Influenza Report ([www.health.act.gov.au/about-our-health-system/population-health/winter-wellbeing-and-flu/flu-act](http://www.health.act.gov.au/about-our-health-system/population-health/winter-wellbeing-and-flu/flu-act))
- NSW: Influenza Surveillance Report (<http://www.health.nsw.gov.au/Infectious/Influenza/Pages/reports.aspx>)
- QLD: Statewide Weekly Influenza Surveillance Report (<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/surveillance/reports/flu>)
- SA: Weekly Epidemiological Summary (Influenza section) (<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/health+statistics/surveillance+of+notifiable+conditions>)
- TAS: fluTAS Reports ([http://www.dhhs.tas.gov.au/publichealth/communicable\\_diseases\\_prevention\\_unit](http://www.dhhs.tas.gov.au/publichealth/communicable_diseases_prevention_unit))
- VIC: Influenza Surveillance Reports (<https://www2.health.vic.gov.au/public-health/infectious-diseases/infectious-diseases-surveillance/seasonal-influenza-reports>)
- WA: Virus WAtch ([http://ww2.health.wa.gov.au/Articles/F\\_I/Infectious-disease-data/Virus-WAtch](http://ww2.health.wa.gov.au/Articles/F_I/Infectious-disease-data/Virus-WAtch))

Figure 7. Map of influenza activity by state and territory, Australia, 1 to 14 July 2019

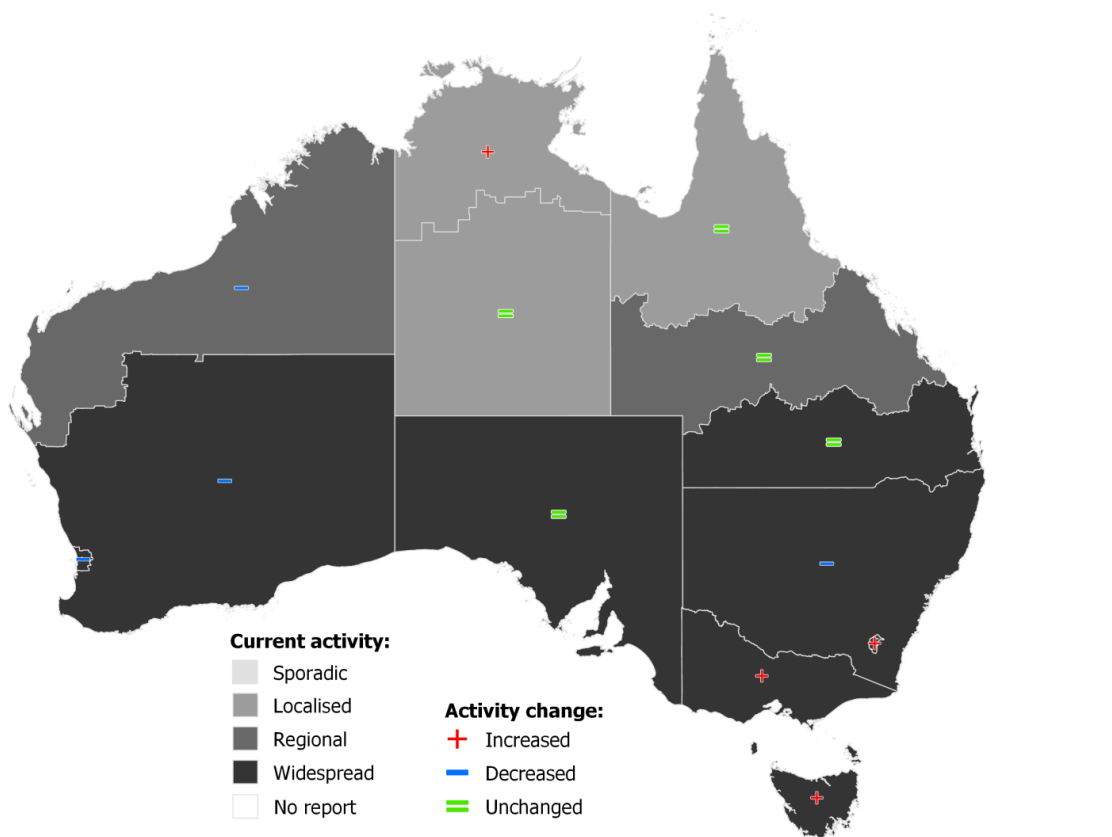
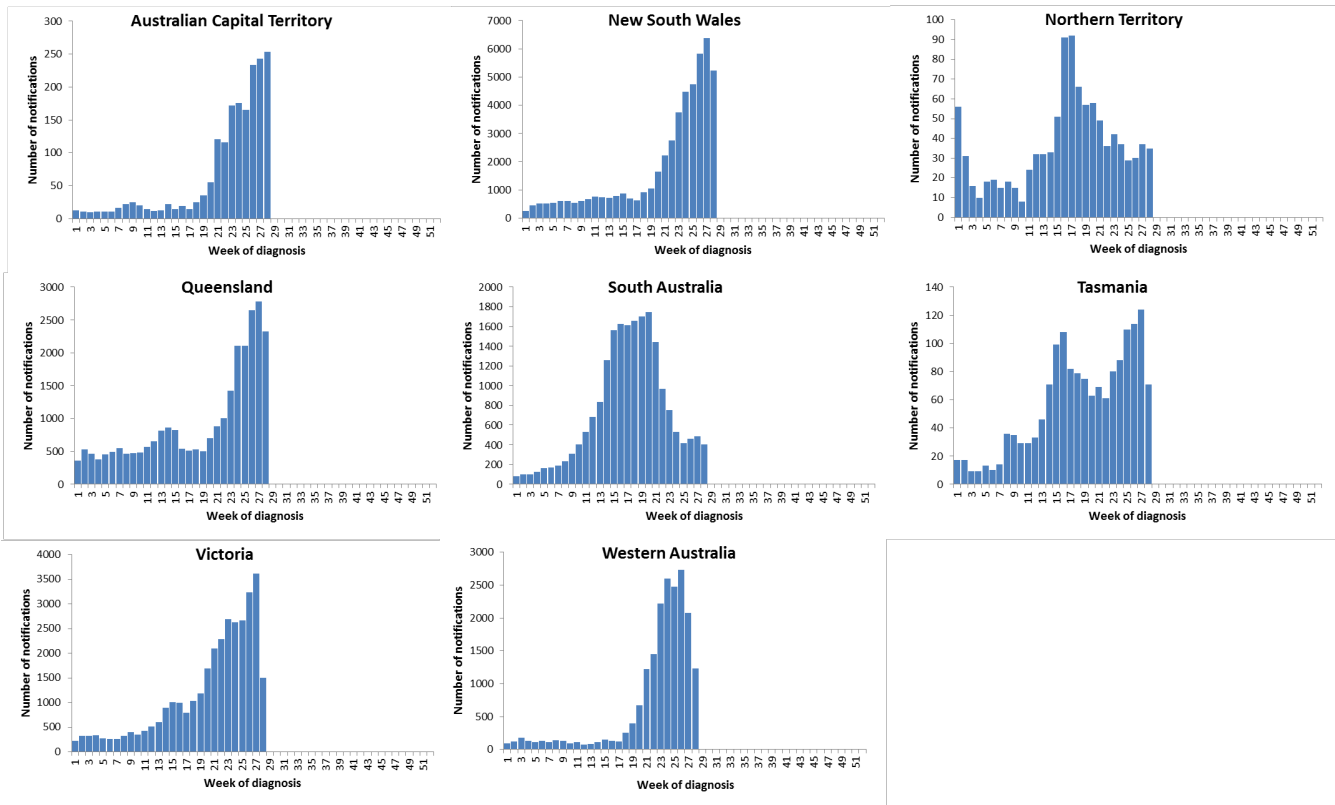


Figure 8. Notifications of laboratory confirmed influenza\*, 1 January to 14 July 2019, by state or territory and week.



Source: NNDSS

\*NNDSS notification data provided for the current and most recent weeks may be incomplete. All data are preliminary and subject to change as updates are received.

## 2. Severity

*Severity is a measure of adverse outcomes or complications as a result of influenza or influenza-like illness (ILI) such as hospital referrals, admissions, need for intensive care and deaths. Measuring and understanding the severity of circulating influenza is difficult to establish at the beginning of the influenza season. The proportion of confirmed influenza cases with serious outcomes might be skewed initially because there are only a small number of people notified with influenza at the beginning of the season. This means that the measure of severity will vary substantially fortnight to fortnight until after the peak of the season when there is enough data for measurements to stabilise. An assessment of severity can be provided once the signals become clearer.*

Clinical severity for the season to date, as measured through the proportion of patients admitted directly to ICU, and deaths attributed to influenza, is low.

### Intensive care admissions

- **FluCAN:** Since seasonal sentinel hospital surveillance began on 1 April 2019, 1,832 people with influenza have been admitted to sentinel hospitals. Of those admitted, 114 (6.2%) were admitted to ICU. In the fortnight to 14 July 2019, 5 of the 218 people admitted to sentinel hospitals with confirmed influenza (2.2%) were admitted to ICU. This is a decrease in the proportion of people admitted to ICU compared to the previous fortnight (5.0%).

### Deaths in confirmed influenza cases

- **NNDSS:** So far in 2019, 328 influenza-associated deaths have been notified to the NNDSS. The majority of deaths were due to influenza A (99%, n=234). Where subtyping information was available, 44 were associated with influenza A(H3N2), 22 with influenza A(H1N1)pdm09, and 4 with influenza B. The median age of deaths notified was 85 years (range <1 to 105 years).

*The number of influenza-associated deaths reported to the NNDSS does not represent the true mortality associated with this disease. The number of deaths is reliant on the follow up of cases to determine the outcome of their infection. The follow up of cases is not a requirement of notification, and are only inclusive of laboratory-confirmed cases of influenza. Due to retrospective revision, the variation across jurisdictions in methodology, representativeness and timeliness of death data, and reporting of an outcome of infection not being a requirement of notification, year on year comparisons of deaths in notified cases of influenza may not be reliable.*

## 3. Impact

*Impact measures how the influenza epidemic affects society, including stress on health-care resources and societal and economic consequences.*

### Absenteeism

- **Flutracking:** In weeks 27 and 28, 1.8% and 1.3% of Flutracking survey respondents respectively reported having ILI and taking time off regular duties while unwell, which is within the range the last five years for the same period. This is a slight decrease from the 1.9% reporting ILI and absence in week 24.

### Use of hospital beds

- **FluCAN:** Since seasonal sentinel hospital surveillance began on 1 April 2019, a cumulative total of 26.6% of hospital beds available in FluCAN hospitals were occupied by patients with confirmed influenza. In the past fortnight, 3.2% of beds were occupied with patients with confirmed influenza, compared to 5.0% in the previous fortnight. This is within the range of the rate of influenza admissions per 1000 available hospital beds in the past 5 years. However, it is likely that a number of hospitals may have a backlog of cases, and it is expected that numbers may be revised upwards.

## 4. Virology

### National notification data

- **NNDSS:** In the reporting fortnight, 77% of notifications of laboratory confirmed influenza to the NNDSS were influenza A (74% influenza A(unsubtyped), <1% influenza A(H1N1)pdm09 and 3% influenza A(H3N2)), 22% were influenza B and less than 1% were influenza A&B co-infections or untyped (Figure 9). This is a decrease in the proportion of cases reported as influenza B compared to the previous fortnight (25%).



- For the year to 14 July 2019, 83% of notifications of laboratory confirmed influenza to the NNDSS were influenza A (77% influenza A(untyped), 2% influenza A(H1N1)pdm09 and 4% influenza A(H3N2)), 17% were influenza B, and less than 1% were influenza A&B co-infections or untyped. The proportion of all notifications year to date reported as influenza A has ranged across jurisdictions from 73% in WA to 95% in TAS (Figure 10).

#### Reference Laboratory data

- World Health Organization Collaborating Centre for Reference and Research on Influenza (WHOCC):** From 1 January to 14 July 2019, the WHOCC characterised 912 influenza viruses. Of these, 89% were influenza A (56% influenza A(H1N1)pdm09 and 33% influenza A(H3N2)), and 11% were influenza B (2% influenza B Yamagata lineage and 9% influenza B Victoria lineage).

#### Sentinel laboratory surveillance

- In the reporting fortnight, 79% of influenza positive samples detected in sentinel laboratories were influenza A (64% were influenza A(untyped), 13% were influenza A(H3N2), and less than 1% were influenza A(H1N1)pdm09), and 21% were influenza B (Figure 11).

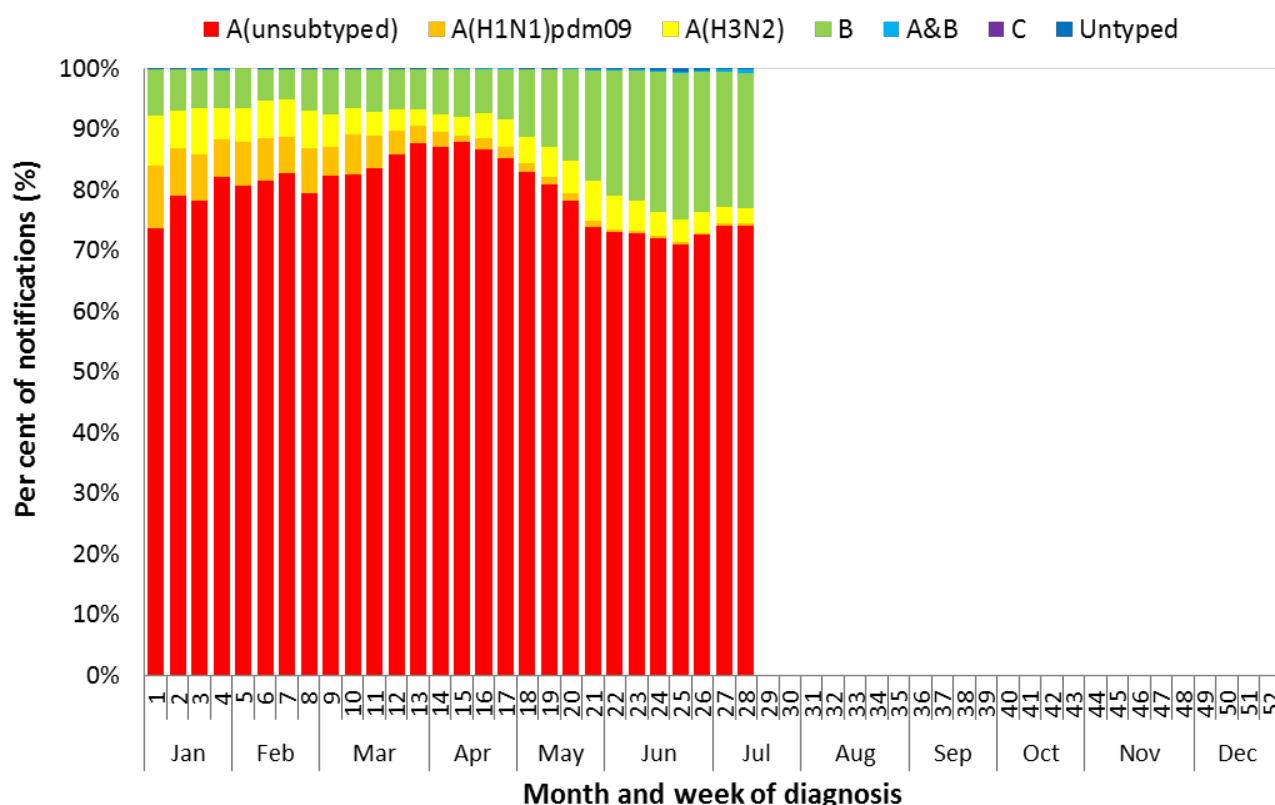
#### Sentinel GP surveillance

- ASPREN:** Of the 90 influenza positive samples detected this fortnight through swab testing patients presenting with ILI to ASPREN sentinel GPs, 2% were influenza A (untyped), 71% were influenza A(H3N2) and 6% were influenza A(H1N1)pdm09. The remaining 19 (21%) were influenza B (Figure 12).

#### Sentinel hospital surveillance

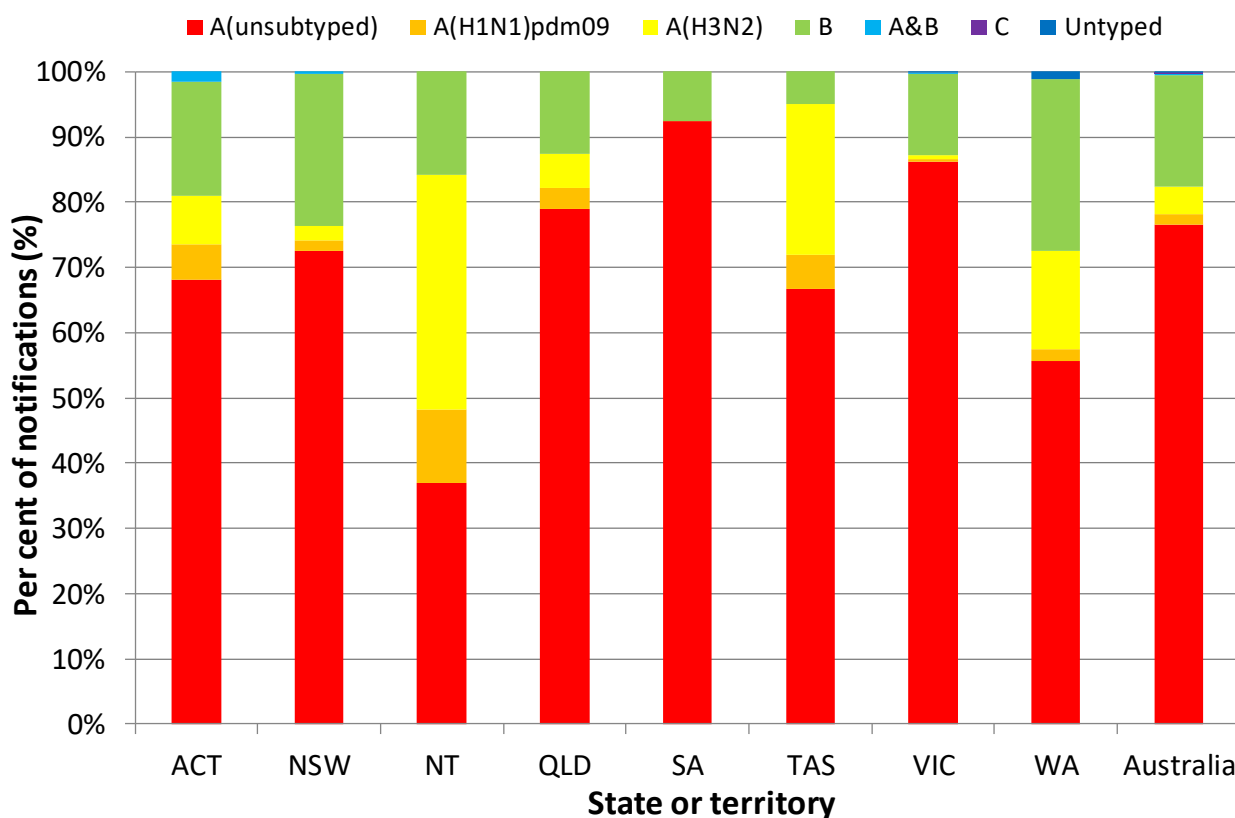
- FluCAN:** Since seasonal sentinel hospital surveillance began on 1 April 2019, 86% of admissions with confirmed influenza to sentinel hospitals were influenza A (62% A(untyped), 4% influenza A(H1N1)pdm09 and 20% influenza A (H3N2)) and 14% were influenza B (Figure 13). Of the 114 patients admitted directly to ICU, 104 patients were infected with influenza A (60% influenza A(untyped), 21% influenza A(H3N2) and 10% influenza A(H1N1)pdm09), with 10 people infected with influenza B (9%).

**Figure 9. Per cent of laboratory confirmed influenza, Australia, 1 January to 14 July 2019 by subtype and week.**



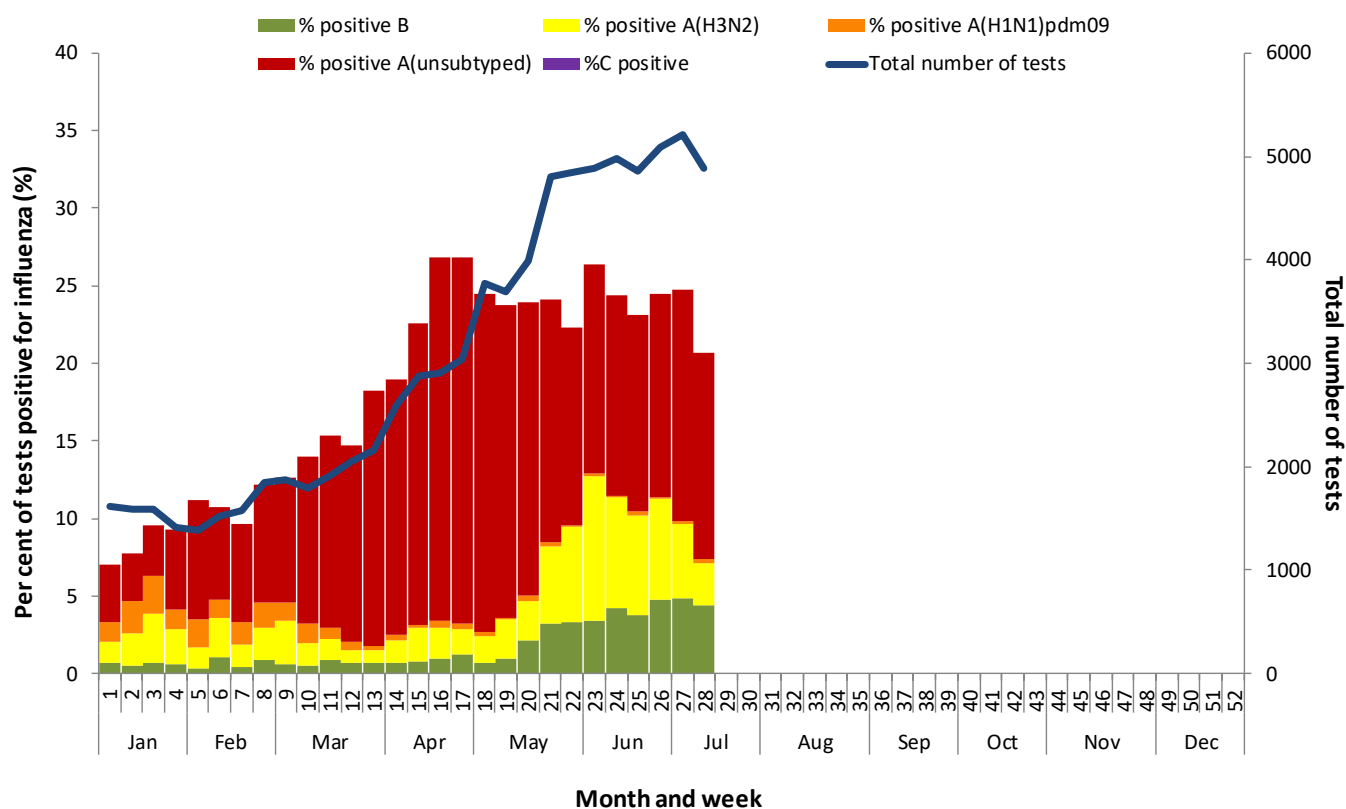
Source: NNDSS

**Figure 10. Per cent of notifications of laboratory confirmed influenza, Australia, 1 January to 14 July 2019, by subtype and state or territory.**

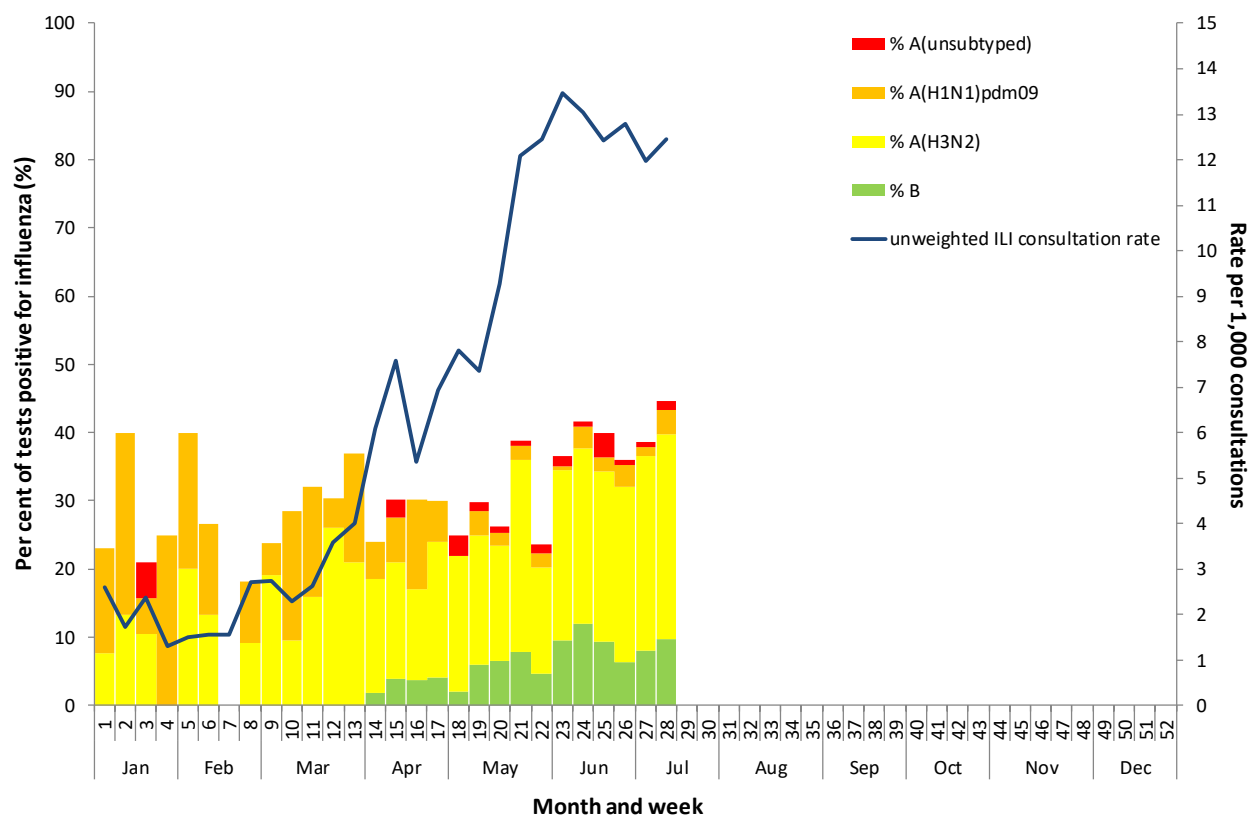


Source: NNDSS

**Figure 11. Proportion of sentinel laboratory tests positive for influenza and total number of specimens tested, 1 January to 14 July 2019, by subtype and month and week.**

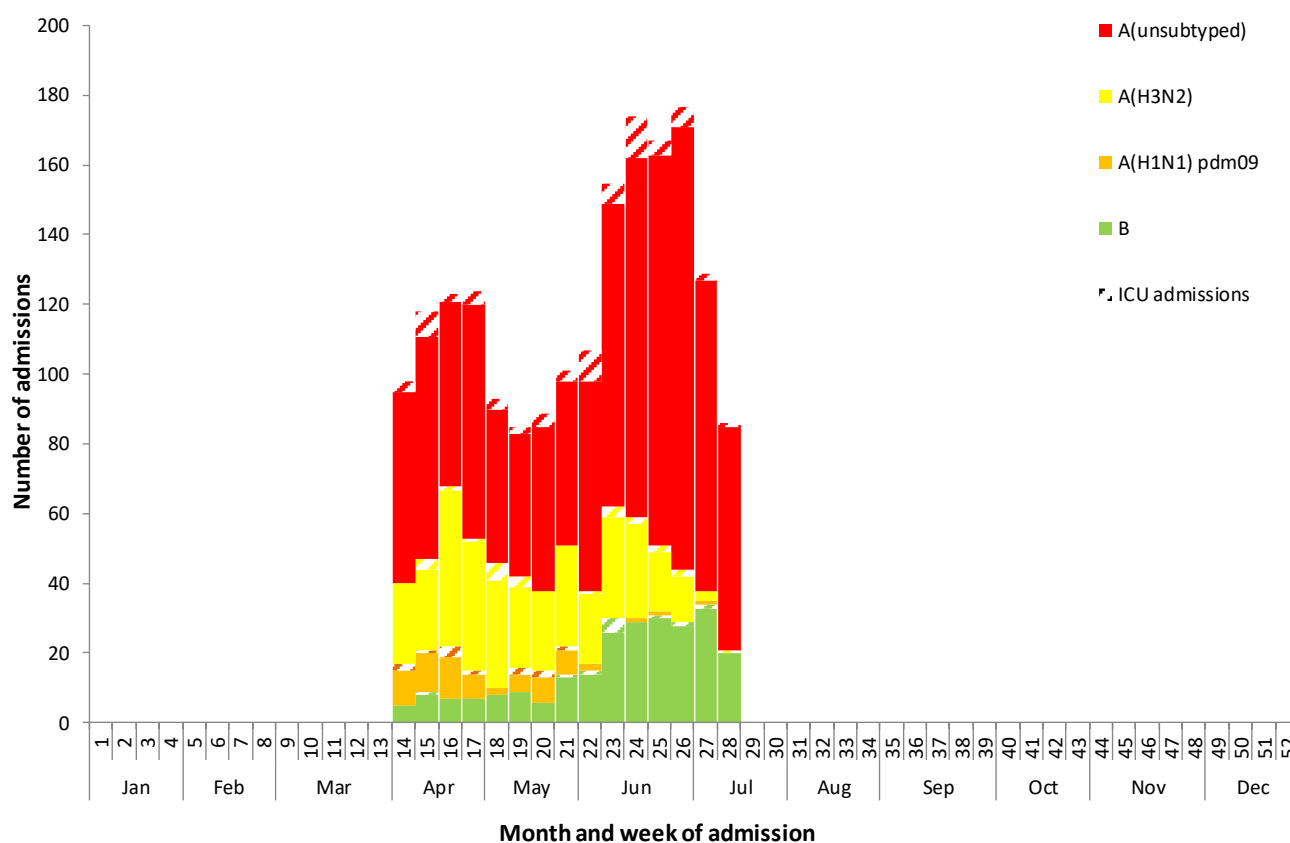


**Figure 12. Proportion of respiratory viral tests positive for influenza in ASPREN ILI patients and ASPREN ILI consultation rate, Australia, 1 January to 14 July 2019, by month and week.**



Source: ASPREN

**Figure 13. Number of influenza hospitalisations at sentinel hospitals by subtype and ICU admission, 1 April to 14 July 2019, by month and week.**



Source: FluCAN

## 5. At-risk Populations

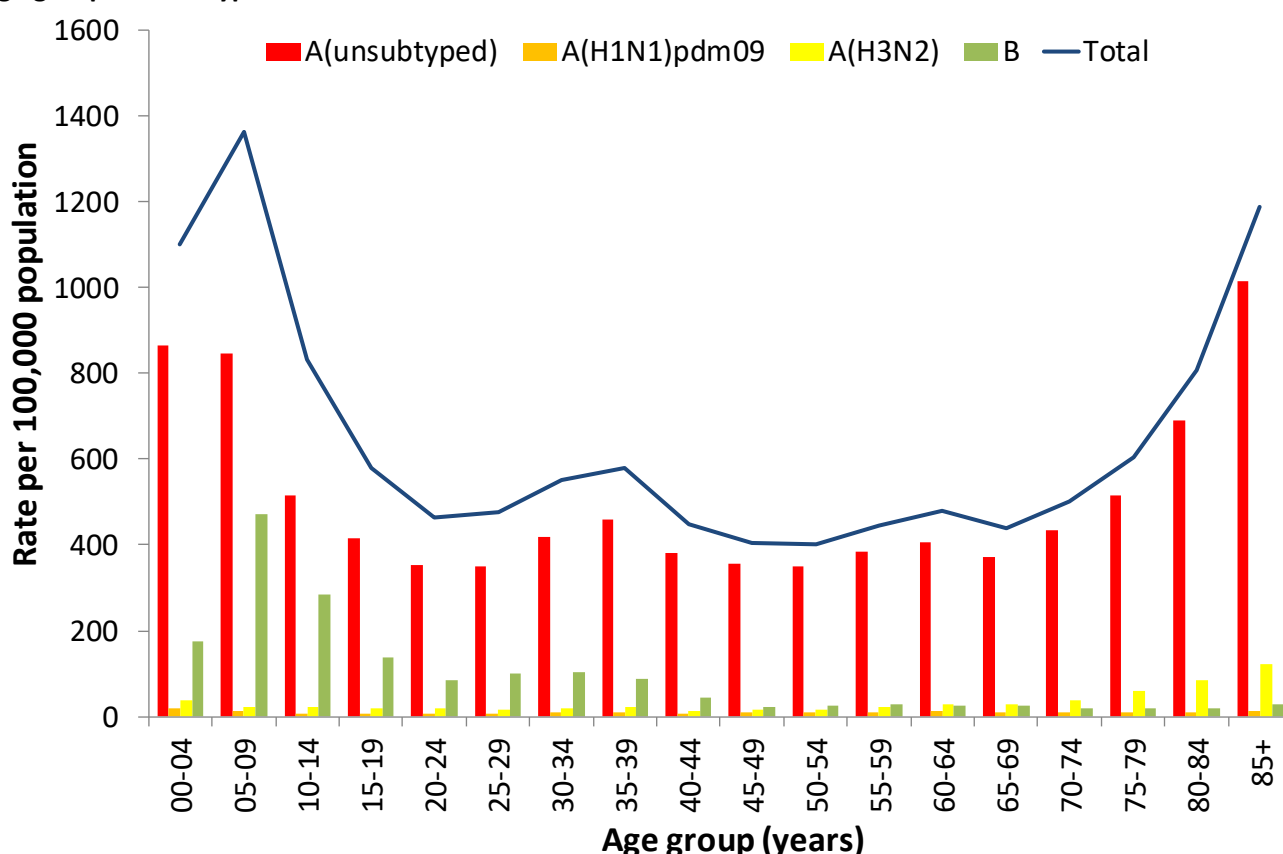
### National notification data

- **NNDSS:** As of 14 July 2019, notification rates were highest in children aged between 5 and 9 years of age (1363.6 notifications per 100,000) followed by adults aged over 85 years (1187.2 notifications per 100,000) (Figure 14).
- In the year to date, Influenza A accounted for the greatest number of notifications across all age groups. Where further subtyping was available, notifications of influenza A(H1N1)pdm09 were highest in children aged less than 4 years (18.9 notifications per 100,000) and notifications of influenza A(H3N2) were highest in adults aged 85 years and older (123.4 notifications per 100,000). Notification rates for influenza B were highest in children aged 5 to 9 years (473 notifications per 100,000), nearly twice that of the next greatest rate in children aged 10 to 14 years (285 notifications per 100,000).
- Among broader age groups, where further subtyping information was available, influenza B was the predominant subtype in children of all ages and adults between the ages of 20 and 64 years, whereas influenza A(H3N2) was the predominant subtype in adults aged 65 years and older (Figure 15). It should be noted that the decrease in cases diagnosed in the past fortnight illustrated in Figure 15 is likely due to data entry backlogs at the jurisdictional level.
- In the past fortnight, notification rates were highest in children aged between 5 and 9 years of age (255 notifications per 100,000) followed by children aged 4 years and younger (216.8 notifications per 100,000).
- In the past fortnight, influenza A has also accounted for the greatest number of notifications across all age groups, with rates according to subtypes mirroring those in the year to date.

### Sentinel hospital surveillance

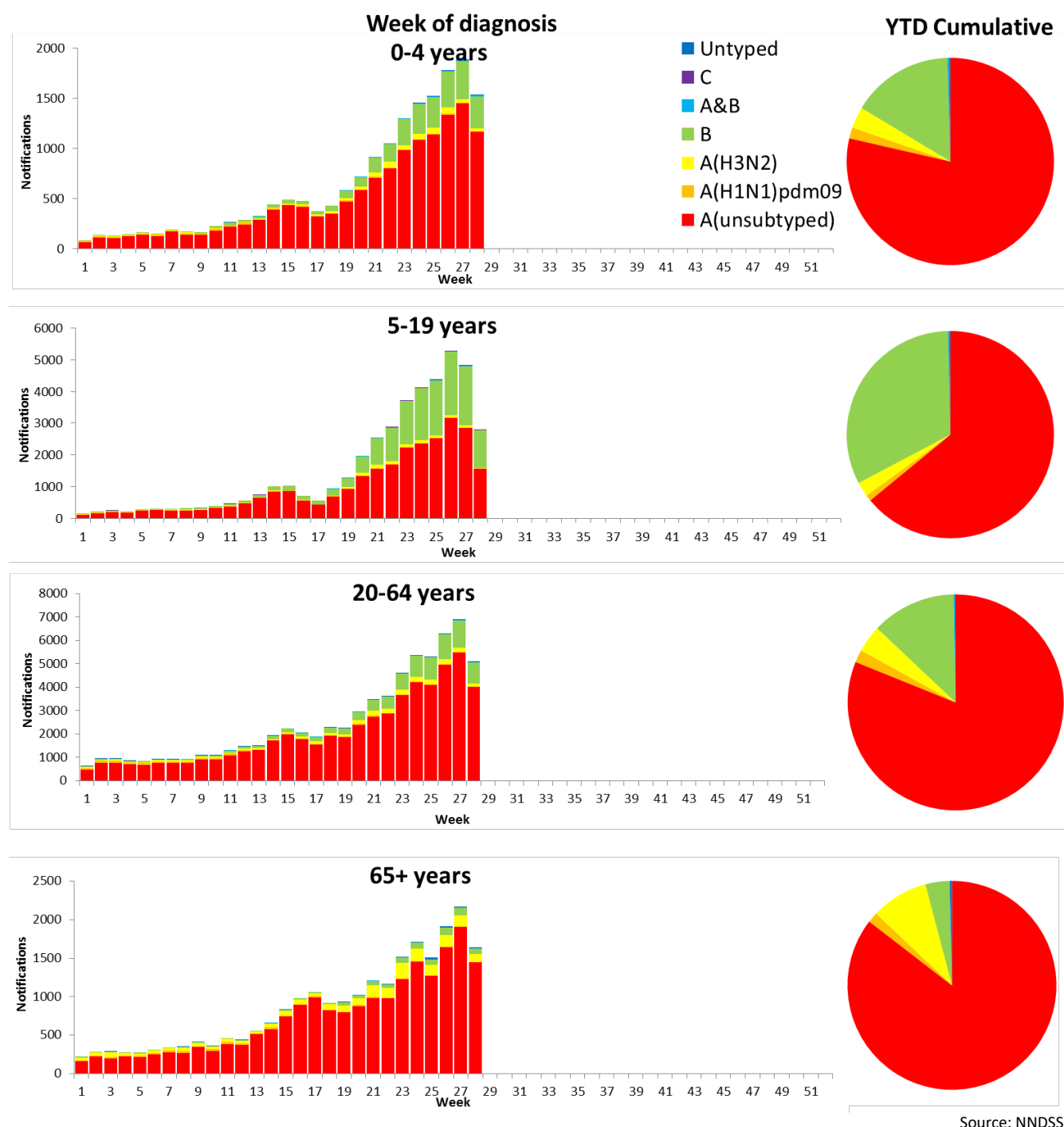
- **FluCAN:** Since seasonal sentinel hospital surveillance began on 1 April 2019, 35% of people admitted with confirmed influenza were children aged 15 years and younger, 32% were adults aged between 16 and 64 years, and 33% were adults aged 65 years and older. Of the children admitted with confirmed influenza to date, 4.7% (n=30) were admitted to ICU, compared to 9.0% of adults aged between 16 and 64 years and 5.3% of adults aged 65 years and older.

**Figure 14. Rate of notifications of laboratory confirmed influenza, Australia, 1 January to 14 July 2019, by age group and subtype.**



Source: NNDSS

**Figure 15. Notifications of laboratory confirmed influenza by week of diagnosis and cumulative year-to-date, Australia, 1 January to 14 July 2019, by age group and subtype**



## 6. Vaccine effectiveness

### Australian Influenza Vaccines Composition 2019

The influenza virus strains included in the 2019 seasonal influenza vaccines in Australia are:

- A/Michigan/45/2015, (H1N1)pdm09-like virus;
- A/Switzerland/8060/2017, (H3N2)-like virus; and
- B/Phuket/3073/2013-like virus, Yamagata lineage.
- B/Colorado/06/2017-like virus, Victoria lineage.

The best way to determine how well the vaccine protects against circulating viruses during the season is by determining the vaccine effectiveness. These estimates provide an indication of how effective the vaccine was in providing protection against influenza infection

## WHOCC

From 1 January to 15 July 2019, 912 isolates were characterised for similarity to their corresponding vaccine components by haemagglutination inhibition (HI) assay (Table 1). Most influenza A(H1N1)pdm09 viruses and influenza B/Yamagata viruses appeared to be antigenically similar to the corresponding vaccine components. 14 A(H1N1)pdm09 and no B/Yamagata viruses were characterised as low reactors. The majority of influenza A(H3N2) and B/Victoria isolates that were able to be assessed by HI assay appeared to be antigenically matched to the vaccine. Of the 254 influenza A(H3N2) isolates, 55 were characterised as low reactors, and an additional 124 isolates were unable to be characterised in the HI assay due to insufficient haemagglutination titre. Of the 78 influenza B/Victoria isolates, 24 were characterised as low reactors.

**Table 1. Australian influenza viruses typed by HI from the WHOCC, 1 January to 15 July 2019.**

Type/Subtype	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	TOTAL
A(H1N1) pdm09	51	176	45	59	86	9	104	26	556
A(H3N2)	34	62	34	15	42	11	43	13	254
B/Victoria lineage	9	7	21	10	9	1	16	5	78
B/Yamagata lineage	4	6	1	1	9	0	1	2	24
Total	98	251	101	85	146	21	164	46	912

SOURCE: WHO CC

Note: Viruses tested by the WHO CC are not necessarily a random sample of all those in the community.

State indicates the residential location for the individual tested, not the submitting laboratory.

There may be up to a month delay on reporting of samples.

## 7. Antiviral Resistance

The WHOCC reported that from 1 January to 15 July 2019, one of the 1,209 influenza viruses tested for neuraminidase inhibitor resistance, one virus demonstrated reduced inhibition to Oseltamivir.

## 8. Data considerations

This report presents an overview of influenza activity based on a number of complimentary systems. No one single system, including notification data, provides the full picture on influenza, because influenza is a common disease and its presenting symptoms are non-specific. The epidemiology of influenza is informed by a number of different systems based in the community, laboratories, primary care and hospitals, as well as notifiable diseases data, which includes officially reported deaths. The information in this report is reliant on the surveillance sources available to the Department of Health at the time of production.

Data in this summary is reported by International Organization for Standardization (ISO) 8601 weeks, with the week ending on Sunday. Throughout the summary, where the year to date is presented, this includes data from 1 January to 14 July 2019. NNDSS data were extracted on 17 July 2019. Due to the dynamic nature of the NNDSS and other surveillance systems, data in this report are subject to retrospective revision and may vary from data reported in other national reports and reports by states and territories. Detailed notes on interpreting the data presented in this report are available at the Department of Health's [Australian Influenza Surveillance Report website](http://www.health.gov.au/flureport) (www.health.gov.au/flureport).

While every care has been taken in preparing this report, the Commonwealth does not accept liability for any injury or loss or damage arising from the use of, or reliance upon, the content of the report. Delays in the reporting of data may cause data to change retrospectively. For further details about information contained in this report please contact the [Influenza Surveillance Team](mailto:flu@health.gov.au) (flu@health.gov.au).