Epidemiology of influenza-like illness during pandemic (H1N1) 2009, New South Wales, Australia

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Abstract
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To rapidly describe the epidemiology of influenza-like illness (ILI) during the 2009 winter epidemic of pandemic (H1N1) 2009 virus in New South Wales, Australia, we used results of a continuous population health survey. During July–September 2009, ILI was experienced by 23% of the population. Among these persons, 51% were unable to undertake normal duties for <3 days, 55% sought care at a general practice, and 5% went to a hospital. Factors independently associated with ILI were younger age, daily smoking, and obesity. Effectiveness of prepandemic seasonal vaccine was ≈20%. The high prevalence of risk factors associated with a substantially increased risk for ILI deserves greater recognition.

During winter 2009, Australia experienced a strong influenza epidemic, caused by the pandemic (H1N1) 2009 virus. In New South Wales (NSW), the most populous state of Australia (~7 million persons), the epidemic lasted from late June through early September (1). Despite intense surveillance and response efforts, determining the epidemiology of influenza at the whole-population level remains difficult, and considerable uncertainty about the disease remains because only a small proportion of infected persons are tested (2).

Survey methods have been infrequently used to assess the epidemiology of pandemic influenza virus infection in the general population. In 1919, a personal household interview survey using a sample of population census districts from large population centers was used to assess illness associated with the first wave of pandemic influenza in the United States. Persons called intelligent inspectors determined whether the household member was “sick since September 1, 1918, with influenza, pneumonia, or indefinitely diagnosed illness suspected to be influenza.” The survey demonstrated substantial demographic, geographic, and socioeconomic variation in the apparent attack rate of influenza. Expressed as a percentage, the overall incidence rate of clinical infection was estimated to be ≈28% during the first wave. The incidence rate was ≈35% in children and declined with age to ≈30% in adults <35 years of age and to ≈10% in persons >75 years of age. Incidence was higher among women 15–35 years of age than among men in the same age group (3,4).

During the first epidemic wave of pandemic (H1N1) 2009, we used a continuous population health survey to better understand the epidemiology of the influenza (H1N1) virus in the general community. This situation also created an unprecedented opportunity to assess the prevalence of seasonal influenza vaccination among persons of all age groups in our population and its effectiveness against ILI during pandemic (H1N1) 2009.

**Methods**

Since 2002, the NSW Population Health Survey has been operating continuously to provide monthly estimates of health status and risk factors. The survey involves computer-assisted telephone interviews of a randomly selected member of randomly selected households. The target population is state residents in private households with private telephones. The sample is selected by using telephone number ranges obtained from an electronic telephone book that has been geocoded (spatial coordinates assigned to addresses) and stratified by 8 regional health
service boundaries within the state. List-assisted random-dig
dialing is then used to contact households. The target
sample is ≈1,500 persons per regional health service per
year, which equals 12,000 persons per year for the state. The
survey covers all age groups, and interviews for children
<16 years of age are reported by a parent or caregiver. Full
details of sample selection and procedures are provided by
Barr et al. (5). The survey has been approved by the NSW
Population Health and Health Services Research Ethics
Committee.

When circulation of pandemic (H1N1) 2009 virus in
NSW became apparent, ethics approval was obtained to
add supplementary questions to the survey to determine the
incidence of influenza–like illness in the population and
associated health care–seeking behavior and absence from
normal duties; these questions were added on July 19, 2009.
The questions were as follows: “In the last 4 weeks, did you
have an illness with any of the following symptoms: fever
or high temperature, cough, sore throat, runny nose, fatigue,
chills or shakes, body aches and pains, shortness of breath,
the flu or flu–like symptoms?” Responses were recorded
for each sign or symptom. Respondents answering “yes”
to any sign or symptom were asked the following: “Did
you see a GP for this illness?”; “Did you go to a hospital or
emergency department for this illness?”; and “How many
days were you unable to work, study, or manage day-
to-day activities because of the illness?” At the same
time, we extended the age range for respondents routinely asked
whether they had been “vaccinated or immunized against
flu in the past 12 months” to persons ≥6 months of age.
Previously, the question had been asked only of persons
≥50 years of age. The extended age range would enable
assessment of vaccine effectiveness against ILI.

We defined ILI as self–reported fever or high
temperature with cough and fatigue. In a range of general
practice surveillance systems for seasonal influenza in
Australia, this definition performed better than alternative
definitions; positive predictive value was 23%–60% and
negative predictive value was 64%–91% (6).

To obtain monthly estimates of ILI incidence, for any
respondents reporting a symptom in the past 4 weeks we
assigned their illness to the middle of the reference period,
that is, 14 days before the interview date. This illness date
was then assigned to a month of illness.

Answers to other questions routinely asked in the
survey enabled analysis of additional factors that might be
associated with ILI reporting (7), including age (0–15, 16–
34, 35–49, 50–64, or ≥65 years); sex; household size (1–2
or ≥3 residents); number of children in household (<2 or
≥2); urban or rural location of residence; socioeconomic
disadvantage at respondent’s residential postal code,
which is derived from the Australian Census and takes
into account income, education, occupation, employment
status, indigenous status, housing, and other variables
(index of relative socioeconomic disadvantage [8]: lowest
2 quintiles = disadvantaged and upper 3 quintiles = not
disadvantaged); current asthma (respondents ≥2 years
of age, diagnosis made by a doctor, and symptoms or
treatment in the past 12 months); nongestational diabetes
or high blood glucose status (≥9 years, diagnosis made by a
doctor); smoking status of persons ≥16 years of age (daily
smoker, occasional smoker, ex-smoker, or nonsmoker);
body mass index ([BMI] [weight in kilograms]/[height in
meters]²) of persons ≥2 years of age (>30 = obese, 25 to
<30 = overweight, and <25 = healthy or underweight);
alcohol drinking at levels associated with health risk
(>2 Australian standard drinks [1 standard drink = 10 g
alcohol] on any day) (9); adequate physical activity for
persons ≥16 years of age (at least 150 minutes exercising
per week on ≥5 occasions, adequate or not adequate),
psychological distress score for persons ≥16 years of age
(Kessler–10 scale ([10] high or very high [score ≥22],
moderate, or low); and vaccinated against pneumococcal
disease in the past 5 years for persons ≥50 years of age
(yes or no).

As is standard for household population surveys, the
data record for each survey respondent was assigned a
numeric weighting, which was used in all analyses to scale
their results to the total NSW population. The weighting
value takes into account the probability (by age, sex, and
geographic region) of being selected for participation in
the survey (5). Regression models were used to obtain the
relative risk (RR) of reporting ILI for each of the factors
listed in the previous paragraph. The dependent variable for
each model was ILI, which was assigned 1 of 2 values: 1 if
the respondent met the criteria for ILI and 0 otherwise. The
independent variables were ≥1 factor.

Our modeling strategy was to individually test the
association between each factor and ILI by using a regression
model and then to develop a final model incorporating
multiple factors to assess whether independent associations
remained. Because age was strongly associated with ILI,
we included it as an independent variable in the model for
all single-factor assessments. Factors with p<0.1 for an
individual association were included in the final model.
Despite its nonsignificance, sex was included in the
final model because the prevalence of risk factors in our
population was known to differ by sex.

To estimate RRs from survey data instead of the more
usual odds ratios, we used Poisson regression analysis
with robust variance estimation. RRs were calculated by
using the GENMOD procedure included in SAS Statistical
Analysis Software version 9.1.3 for Windows (Cary,
NC, USA) with the following programming statements:
model statement with options dist = Poisson and
link = log; a class statement including the unique survey
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respondent number variable; a repeated statement with an independent correlation structure (corr = ind) and specifying the unique survey respondent number variable as the subject parameter; and a weight statement specifying the respondent sample weighting normalized to sum to the total sample size (II–13). Because the Poisson model uses the natural logarithm as the link function, exponentiation of the parameter estimates was used to obtain the RR for the study factors.

Vaccine effectiveness for ILI was estimated by 1–RR. RR was the age-adjusted relative risk of reporting ILI among respondents reporting seasonal influenza vaccination in the past 12 months relative to that for unvaccinated respondents. RRs were obtained from the regression analysis (14).

Results

Incidence of ILI

From July 19 through October 14, 2009, completed interviews were obtained from 2,909 respondents from 5,017 eligible households contacted during that period. Participation rate was 58.0%.

During July 2009, estimated ILI incidence was 12.1% (95% confidence interval [CI] 9.1%–15.0%), representing 850,000 (95% CI 640,000–1,060,000) persons (Table 1). Incidence declined to 7.4% (95% CI 5.3%–9.5%) in August, and 3.6% (95% CI 1.2%–5.9%) in September. Assuming that during the 3-month window each person could only experience ILI 1 time, the monthly incidence can be summed to provide an estimate of the total proportion of the population experiencing ILI during that period. This calculation indicated that an estimated 23.1% (95% CI 18.8%–59.9%) of the NSW population, or 1,630,000 (95% CI 1,330,000–4,240,000) persons, experienced ILI during that period.

The only significant difference was the low incidence for persons ≥65 years of age (5.1%; 95% CI 2.4%–7.9%), compared with estimates of 19.1% (95% CI 11.9%–26.2%) for those 50–64 years of age and 33.3% (95% CI 24.7%–42.0%) for those 0–15 years of age (Table 2). Estimates were higher for female than male respondents and for residents of rural areas, but these differences were not significant.

Outcome of ILI

Inability to undertake normal duties for ≤3 days was reported by approximately half (51%, 95% CI 41%–61%) of those reporting ILI (Table 3). Another 12% (95% CI 6%–18%) were unable to continue their usual duties for at least 7 days. Approximately half (55%) sought care at a general practice (95% CI 46%–65%), and 5% (95% CI 1%–9%) sought care at a hospital.
Table 3. Illness outcomes for persons reported influenza–like illness, New South Wales, Australia, July–September 2009*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Estimated no. persons, millions (95% CI)†</th>
<th>Proportion, % (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. days unable to do usual activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–3</td>
<td>0.83 (0.67–1.00)</td>
<td>51.3 (41.4–61.1)</td>
</tr>
<tr>
<td>4–7</td>
<td>0.60 (0.44–0.76)</td>
<td>36.7 (26.9–46.5)</td>
</tr>
<tr>
<td>&gt;7</td>
<td>0.20 (0.09–0.30)</td>
<td>12.0 (5.7–18.4)</td>
</tr>
<tr>
<td>Type of health care sought</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practice</td>
<td>0.90 (0.74–1.06)</td>
<td>55.4 (45.5–65.2)</td>
</tr>
<tr>
<td>Hospital</td>
<td>0.08 (0.02–0.15)</td>
<td>5.2 (1.3–9.2)</td>
</tr>
<tr>
<td>General practice and hospital‡</td>
<td>0.04 (0.01–0.07)</td>
<td>2.3 (0.5–4.1)</td>
</tr>
<tr>
<td>Neither general practice nor hospital</td>
<td>0.68 (0.53–0.83)</td>
<td>41.7 (32.3–51.1)</td>
</tr>
</tbody>
</table>

†The estimated numbers were obtained by applying the proportions and 95% CIs in this table to the estimated 1.63 million persons with influenza–like illness (Table 1). Standard errors of that estimate were ignored.
‡Because this category overlaps the 2 categories above, total is not 100%.

The association with younger age remained in the final model (Table 6). Among the 13.0% (95% CI 10.8–15.1%) of the population ≥16 years of age who reported daily smoking, the risk for ILI was 90% (95% CI 10%–226%) higher than that for less frequent smokers and nonsmokers combined. Among the 18.0% (95% CI 15.9–20.1%) whose BMI was in the obese category, the risk for ILI was 132% (95% CI 30%–316%) greater than that for the combined group of persons whose BMI was healthy or underweight.

**Effectiveness of Seasonal Influenza Vaccine**

When the age-adjusted RR for ILI among persons reporting vaccination with the seasonal influenza vaccine in the past 12 months was used, the estimated vaccine effectiveness was 20.0% (95% CI –30.5% to 51.0%), indicating a possibly mild but nonsignificant benefit. Analysis of effectiveness in specific age groups and by sex, region, smoking status, or obesity did not indicate any significant benefit (Table 7).

**Discussion**

In NSW, during the first Southern Hemisphere winter in which pandemic (H1N1) 2009 virus was circulating, at least one quarter of the population and one third of children experienced ILI. Many infections other than influenza can cause ILI (15,16); however, this study was conducted during the peak months of the epidemic in NSW, when the predictive value of ILI for influenza infection would be optimal (6). The epidemic was recognized in Australia after mid-June and grew rapidly (1). We were able to obtain full monthly estimates of ILI from July only. Late June was part of the recall period of the survey questions for respondents interviewed in July, and some of that activity may have been included in the July estimate.

ILI incidence was similar in urban and rural regions and in each sex. Approximately half the persons who reported ILI had to limit their usual activities for <4 days. Approximately half sought care for their illness at a general practice, and 5% sought care at a hospital. Vaccination against seasonal influenza did not protect against ILI. Daily smoking and obesity each independently doubled the risk for ILI.

Consistent with the known epidemiology of pandemic (H1N1) 2009 virus infection (1,17–19), incidence of ILI decreased with age; the decline was sharp for those ≥65 years of age. The age-specific estimates of ILI incidence in NSW in 2009 were remarkably similar to those reported during the 1918 influenza pandemic in the United States (4). Our overall estimate of an ILI rate of 23% was higher than the overall population infection rate for pandemic (H1N1) 2009 of 16% estimated by a recent seroprevalence study from NSW (20). Although the CIs of both estimates overlapped and thus the estimates did not differ significantly, explanations for our higher estimate could be as follows: 1) some of the ILI in our study was caused by other influenza strains that circulated earlier in the season (1) and by pathogens other than influenza; 2) our study included information collected through the end of September, whereas the seroprevalence study included some specimens collected before the end of the epidemic.
RESEARCH

Table 5. Risk factors evaluated for influenza-like illness, New South Wales, Australia, July–September 2009*

<table>
<thead>
<tr>
<th>Factor</th>
<th>Factor prevalence, % (95% CI)</th>
<th>Reference category†</th>
<th>Age group analyzed (no. respondents)‡</th>
<th>Relative risk (95% CI)</th>
<th>p value§</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–15</td>
<td>21.4 (19.4–23.5)</td>
<td>≥65 y</td>
<td>All ages (2,909)</td>
<td>5.96 (3.25–10.93)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>16–34</td>
<td>26.0 (23.2–28.8)</td>
<td></td>
<td></td>
<td>4.76 (2.35–9.62)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>35–49</td>
<td>21.7 (19.4–23.9)</td>
<td></td>
<td></td>
<td>3.55 (1.86–7.97)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>50–64</td>
<td>17.7 (16.1–19.3)</td>
<td></td>
<td></td>
<td>3.00 (1.57–5.71)</td>
<td>0.001</td>
</tr>
<tr>
<td>Female sex¶</td>
<td>50.5 (47.8–53.2)</td>
<td>Male</td>
<td>All ages (2,909)</td>
<td>1.31 (0.89–1.94)</td>
<td>0.173</td>
</tr>
<tr>
<td>Rural region¶</td>
<td>29.9 (28.4–31.4)</td>
<td>Urban</td>
<td>All ages (2,909)</td>
<td>1.26 (0.87–1.84)</td>
<td>0.227</td>
</tr>
<tr>
<td>Socioeconomically disadvantaged¶</td>
<td>38.4 (35.9–40.9)</td>
<td>Not disadvantaged</td>
<td>All ages (2,909)</td>
<td>0.93 (0.63–1.38)</td>
<td>0.729</td>
</tr>
<tr>
<td>≥2 children in household¶</td>
<td>34.5 (31.9–37.2)</td>
<td>&lt;2 children residing in household</td>
<td>All ages (2,909)</td>
<td>0.75 (0.51–1.10)</td>
<td>0.142</td>
</tr>
<tr>
<td>&gt;3 persons in household¶</td>
<td>67.7 (65.6–69.7)</td>
<td>1–2 persons in household</td>
<td>All ages (2,909)</td>
<td>1.14 (0.75–1.72)</td>
<td>0.536</td>
</tr>
<tr>
<td>Seasonal influenza vaccination in past 12 mo¶</td>
<td>25.6 (23.5–27.7)</td>
<td>No seasonal influenza vaccination in past 12 mo</td>
<td>≥6 mo (2,888)</td>
<td>0.80 (0.49–1.31)</td>
<td>0.372</td>
</tr>
<tr>
<td>Current asthma¶</td>
<td>11.4 (9.8–13.0)</td>
<td>No current asthma</td>
<td>≥2 y (2,831)</td>
<td>1.15 (0.69–1.92)</td>
<td>0.595</td>
</tr>
<tr>
<td>Body mass index¶</td>
<td>18.0 (15.9–20.1)</td>
<td>Healthy or underweight</td>
<td>All ages (2,909)</td>
<td>2.14 (1.31–3.48)</td>
<td>0.002</td>
</tr>
<tr>
<td>Overweight</td>
<td>28.6 (26.3–31.0)</td>
<td>Healthy or underweight</td>
<td>All ages (2,909)</td>
<td>1.06 (0.67–1.67)</td>
<td>0.816</td>
</tr>
<tr>
<td>Current diabetes or high blood glucose¶</td>
<td>8.0 (6.7–9.2)</td>
<td>No current diabetes or high blood glucose</td>
<td>≥9 y (2,636)</td>
<td>0.97 (0.50–1.91)</td>
<td>0.936</td>
</tr>
<tr>
<td>Daily smoker¶</td>
<td>13.0 (10.8–15.1)</td>
<td>Occasional/ex-/non-smoker</td>
<td>≥16 y (2,431)</td>
<td>1.94 (1.06–3.54)</td>
<td>0.031</td>
</tr>
<tr>
<td>Inadequate physical activity¶</td>
<td>48.6 (45.6–51.7)</td>
<td>Adequate physical activity</td>
<td>≥16 y (2,431)</td>
<td>1.04 (0.65–1.65)</td>
<td>0.881</td>
</tr>
<tr>
<td>Risky alcohol drinking¶</td>
<td>31.6 (28.6–34.7)</td>
<td>Low-risk alcohol drinking</td>
<td>≥16 y (2,431)</td>
<td>1.25 (0.76–2.05)</td>
<td>0.378</td>
</tr>
<tr>
<td>High or very high psychological distress score¶</td>
<td>11.2 (9.4–13.1)</td>
<td>Moderate or low psychological distress score</td>
<td>≥16 y (2,431)</td>
<td>1.41 (0.85–2.35)</td>
<td>0.182</td>
</tr>
<tr>
<td>Pneumococcal vaccination in past 5 y¶</td>
<td>28.3 (25.7–30.9)</td>
<td>No pneumococcal vaccination in the past 5 y (adjusted for age)</td>
<td>≥50 y (1,633)</td>
<td>1.20 (0.56–2.56)</td>
<td>0.640</td>
</tr>
</tbody>
</table>

*CI, confidence interval.
†Not stated and “Don’t know” responses were included in the reference category. Among parameters with any such responses, the proportions were 10% of ILI among children, 20% among adults 35–64 years of age, and no influenza among older adults.
‡Some questions are only collected on selected age groups, so sample sizes vary.
§Significant results at the 5% level are in boldface.
¶Adjusted for age.
#Disadvantaged = lowest 2 quintiles of the Australian index of relative socioeconomic disadvantage based on the respondent’s residential postcode; not disadvantaged = upper 3 quintiles.

During August; and 3) population samples differed. However, the seroprevalence study detected mild and asymptomatic infections. Because the seroprevalence study used specimens requested from clinical chemistry laboratories without randomization, statistical biases may arise from the nonrandom sample selection and the disease factors leading to a clinical specimen being required. Age-specific comparisons between the 2 studies were broadly consistent. Serosurvey infection rate estimates were 10%–35% among children, 24% among adults 18–34 years of age, 20% among adults 35–64 years of age, and no infection among older adults. Our estimates for ILI are consistent with results of another study of ILI during seasonal influenza season in Australia (26). This lack of effect may reflect improved living standards in this country.

Other studies that assessed household size and risk for transmission found mixed results: some found increased risk (21,22) and another found decreased risk (23) with increasing household size. A higher number of children in a household has also been identified as a risk factor for influenza transmission in households (24). However, our finding of no association with either household size or number of children in the household is consistent with the result of household transmission studies of the pandemic 2009 (H1N1) virus (18,25) and with results of another study of ILI among children during seasonal influenza season in Australia (26). The subtype H1N1 component of the Northern and Southern Hemisphere vaccines at that time was the same: A/Brisbane/59/2007–like.
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Obesity and smoking are 2 preventable risk factors we found to be strongly associated with ILI. Smoking has been frequently identified as a risk factor for influenza; the identified mechanisms are mechanical, structural, and immunity related (30–32). Although obesity has been frequently identified as a risk factor for severe outcomes of infection with pandemic 2009 (H1N1) virus (33–35), it has not been previously recognized as a risk factor for susceptibility to symptomatic influenza infection in humans. A recent study in mice found that an immune memory response to recent influenza infection was reduced among obese mice; this reduced memory led to more severe disease, lung pathology, and virus titers after a second exposure to the same mouse-adapted influenza strain (36).

In addition to possibly excluding the early part of the epidemic, our study has other limitations. Influenza in respondents was not confirmed by testing; other common winter respiratory viruses, such as respiratory syncytial virus, can cause a similar syndrome (16). General practice surveillance in various regions of Australia, conducted during circulation of seasonal influenza virus, indicated that the syndrome definition we used had a positive predictive value of 23%–60% (6). Although these values are not high, positive predictive value is probably increased during a larger than usual epidemic (37). Pandemic concern may have prompted more persons than usual to get vaccinated for seasonal influenza. This concern and response would produce higher vaccination prevalence in our study than would have occurred in the absence of a pandemic. Evidence shows that publicity prompted increased vaccination among persons >65 years of age, from 68% in April 2009 to 77% in May 2009. Prevalence remained higher for several months (38). In our study, we were unable to include 2 frequently reported risk factors for poor outcomes of pandemic (H1N1) 2009 virus infection: pregnancy and indigenous status (39,40). Although indigenous status is included in the health survey, the number of Aboriginal and pregnant respondents in the period of time covered would be too small to obtain usable estimates for these risk factors.

Table 6. Final model of factors associated with reporting influenza-like illness, New South Wales, Australia, July–September 2009*

<table>
<thead>
<tr>
<th>Factor, n = 2,431 respondents</th>
<th>Prevalence of factor, % (95% CI)</th>
<th>Reference category†</th>
<th>Relative risk (95% CI)</th>
<th>p value‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16–34</td>
<td>26.0 (23.2–28.8)</td>
<td>&gt;65 y</td>
<td>4.74 (2.38–9.45)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>35–49</td>
<td>21.7 (19.4–23.9)</td>
<td></td>
<td>3.25 (1.68–6.26)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>50–64</td>
<td>17.7 (16.1–19.3)</td>
<td></td>
<td>2.60 (1.36–4.99)</td>
<td>0.004</td>
</tr>
<tr>
<td>Female sex</td>
<td>50.5 (47.8–53.2)</td>
<td>Male</td>
<td>1.25 (0.76–2.05)</td>
<td>0.375</td>
</tr>
<tr>
<td>Daily smoker</td>
<td>13.0 (10.8–15.1)</td>
<td>Occasional/ex-/nonsmoker</td>
<td>1.90 (1.10–3.26)</td>
<td>0.021</td>
</tr>
<tr>
<td>Body mass index</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>18.0 (15.9–20.1)</td>
<td>Healthy or underweight</td>
<td>2.32 (1.30–4.16)</td>
<td>0.005</td>
</tr>
<tr>
<td>Overweight</td>
<td>28.6 (26.3–31.0)</td>
<td>Healthy or underweight</td>
<td>1.20 (0.68–2.12)</td>
<td>0.534</td>
</tr>
</tbody>
</table>

*Influenza-like illness defined as fever with cough and fatigue. Some questions are only collected on selected age groups, so sample sizes vary. CI, confidence interval.
†Not stated and “Don’t know” responses were included in the reference category. Among parameters with any such responses, the proportions were body mass index 5.2%; smoking status 0.1%.
‡Statistically significant results at the 5% level are in boldface.

Table 7. Effectiveness of seasonal influenza vaccine against influenza-like illness, New South Wales, Australia, July–September 2009*

<table>
<thead>
<tr>
<th>Subgroup, n = 2,888</th>
<th>Vaccine effectiveness, % (95% CI)†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, y</td>
<td></td>
</tr>
<tr>
<td>0.5–15</td>
<td>6.1 (120.1 to 60.0)</td>
</tr>
<tr>
<td>16–34</td>
<td>44.6 (166.8 to 88.5)</td>
</tr>
<tr>
<td>35–49</td>
<td>–0.9 (137.2 to 57.1)</td>
</tr>
<tr>
<td>50–64</td>
<td>33.7 (69.7 to 74.1)</td>
</tr>
<tr>
<td>&gt;65</td>
<td>–97.9 (622.5 to 45.8)</td>
</tr>
<tr>
<td>Sex†</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>34.5 (71.7 to 75.0)</td>
</tr>
<tr>
<td>F</td>
<td>10.5 (49.2 to 46.4)</td>
</tr>
<tr>
<td>Region†</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>17.1 (55.7 to 55.9)</td>
</tr>
<tr>
<td>Rural</td>
<td>25.5 (49.7 to 62.9)</td>
</tr>
<tr>
<td>Smoking status†</td>
<td></td>
</tr>
<tr>
<td>Daily smoker</td>
<td>1.4 (175.3 to 64.7)</td>
</tr>
<tr>
<td>Not daily smoker</td>
<td>22.3 (53.2 to 60.6)</td>
</tr>
<tr>
<td>Body mass index†</td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td>25.0 (81.6 to 69.1)</td>
</tr>
<tr>
<td>Not obese</td>
<td>9.2 (66.0 to 50.4)</td>
</tr>
<tr>
<td>Overall†</td>
<td>20.0 (30.5 to 51.0)</td>
</tr>
</tbody>
</table>

For persons >6 mo of age vaccinated in past 12 mo. CI, confidence interval.
†Adjusted for age.

Conclusions

When pandemic (H1N1) 2009 virus was circulating in the NSW population, ILI was experienced by at least one quarter of the population. Recent prepandemic seasonal vaccination was not protective. Although smoking is already known to increase susceptibility to influenza infection, obesity is not. The role of obesity in susceptibility needs further evaluation in studies in which influenza infection can be confirmed. The high prevalence of these preventable risk factors in our population, combined with a substantially increased risk for ILI, deserves greater recognition. Using an established health survey for monitoring ILI is
inexpensive and provides an opportunity to assess a broad range of risk factors. Continued monitoring will enable better assessment of the value of survey-based influenza surveillance through comparison with other influenza and respiratory illness surveillance systems and can provide continuous assessment of risk factors for ILI.

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References


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