

Original Research Article

Morbidity profile of patients seeking care in private Siddha facility in Tamil Nadu: a cross-sectional study

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ABSTRACT

Background: The Siddha system of medicine is one of the widely practiced traditional medical systems in South India. Despite increasing utilization of Siddha services in both public and private sectors, evidence on morbidity patterns in private Siddha healthcare facilities is limited. This study aimed to describe the morbidity profile of patients attending Arogya Healthcare Private Limited in Chennai in 2024.

Methods: We conducted a cross-sectional study using outpatient data collected from January to December 2024 from Arogya healthcare private limited clinics, Tamil Nadu. We extracted patient information, including age, sex, and clinical diagnoses, from the Electronic Health Record (EHR) system using a structured data extraction form. We analyzed the data using Epi Info software and present the findings as frequencies and proportions.

Results: We extracted and analyzed 28,049 outpatient data. The majority of patients were female (57.1 %), and belonged to the 31-45-year age group (31%). The most frequently reported conditions were diabetes (12.5%), ulcers (7.4 %), osteoarthritis (7.4%), cold/cough (5.8%) and sinusitis (4.8%). Diabetes was at top in both sexes, but it varied in the following diseases. According to Siddha classification, vali-related disorders (40%) were more commonly reported.

Conclusions: This study describes the morbidity pattern in private Siddha clinic. Many patients sought care were female, came for follow-up and chronic conditions like diabetes, ulcers, and osteoarthritis. The identification of pattern helps in the integration of data for the surveillance and developing standardized preventive and management strategies to reduce disease burden and improve quality of life.

Keywords: Ayush, Morbidity profile, Siddha, Traditional medicine

INTRODUCTION

Traditional and complementary medicine (TCM) refers to ancient, knowledge-based systems of healthcare that exist outside contemporary medicine.¹ Globally, World Health Organization reports that 170 (88%) of its member states utilize TCM, and 13 countries, including India, have integrated such systems into mainstream healthcare delivery systems.² In India, traditional medical systems are recognized under the term Ayush, which includes Ayurveda, Unani, Yoga, Naturopathy, Siddha, Sowa-

Rigpa, and Homoeopathy and integrated with India's healthcare systems. To operationalize this integration, the Government of India launched the National Ayush Mission (NAM) in 2014, followed by expanded services under the National Health Mission (NHM) in 2017 and these initiatives enabled co-location of Ayush services across multiple levels of care in India. Such integration has aimed to enhance accessibility, optimize resource utilization, and promote patient choice within the public health system.³

Among the Ayush systems of medicine, the Siddha system of medicine is widely practiced in South India and is valued for its personalised and holistic approach to diagnosis and treatment.⁴ In public sector Siddha services have expanded, with 1210 facilities across India, the majority located in Tamil Nadu.⁵ In addition to clinical services, Siddha has been incorporated into various public health initiatives, including programmes addressing non-communicable diseases (NCDs), musculoskeletal disorders, school health (Ilam Thilir Thittam), maternal care (Magaperu Sanjeevi Kit), and community outreach activities such as Swasthya Raksha.⁶ The system has played a role in epidemic and pandemic situations, including dengue, chikungunya, and COVID-19.⁷

While public sector Siddha services have expanded under structured policy frameworks, the private sector represents a parallel component of healthcare delivery through outpatient and inpatient services across the districts in Tamil Nadu. Utilization of private healthcare services is often influenced by factors like perceived quality of care, reduced waiting time, accessibility, infrastructure, and patient-provider interaction.^{8,9} These factors may contribute to differences in patient profiles and morbidity patterns between public and private settings.

Morbidity profiling is vital for assessing disease burden and planning resources. It helps us understand disease patterns and healthcare-seeking behaviors within the healthcare system. In India, where the healthcare system comprises both public and private sectors, the latter covers for nearly 70% of healthcare utilization. Data from the National Sample Survey Office (NSSO) shows that 73% in urban areas and 68% in rural areas have utilized the private Ayush facilities.¹⁰ Differences in morbidity patterns between public and private healthcare settings have been reported and are influenced by variations in healthcare-seeking behavior and patient preferences.^{11,12} Notably, despite the higher cost than public sector a significant proportion of the population prefers private healthcare facilities, including AYUSH services, for the management of non-communicable and metabolic disorders.¹³

Several studies from Tamil Nadu and Puducherry have reported morbidity patterns in public Siddha primary and secondary care hospitals.¹⁴⁻¹⁶ Studies highlight the relationship between morbidity patterns and healthcare-seeking behaviour.¹⁷ While patient preference for private healthcare has been explored extensively in the biomedical sector, similar investigations within AYUSH systems, particularly in Siddha practice, remain limited.^{18,19} There is a notable lack of systematic evidence exploring the reasons for choosing private Siddha facilities and the types of conditions commonly managed in these settings.²⁰

Despite the wide presence and utilization of private Siddha facilities, systematic evidence on morbidity

patterns within the private sector remains limited. This represents an important knowledge gap, particularly in the context of integrated health planning and policy formulation. With the growing contribution of private Siddha institutions to healthcare delivery, understanding the types of illnesses commonly managed in these settings becomes increasingly important. Such information can provide practical insights for clinicians, administrators, and policymakers to plan services better, allocate resources appropriately, and strengthen coordination within the broader healthcare system.

METHODS

Study design

This was a cross-sectional study conducted using secondary data collected at Arogya Healthcare Private Limited clinics.

Study setting

Arogya Healthcare Private Limited is a chain of Ayush hospitals with a primary focus on Siddha medicine. The network comprises one National Accreditation Board for Hospitals and Healthcare Providers (NABH) accredited tertiary Siddha hospital located in Chennai, offering both inpatient and outpatient services. In addition, seven outpatient clinics operate across urban locations, including Chennai (four clinics), Coimbatore (one), Salem (one), and Kumbakonam (one).²¹ All study sites were situated in urban areas. On average, approximately 2,000 patients attend these facilities each month.

Study population

All outpatient visits, including both new and follow-up cases, are documented in a centralized Electronic Health Record (EHR) system maintained on a common server. The study included records of all patients who consulted Siddha physicians between January and December 2024. Data for the study period were extracted from the EHR system.

Study variables

Data collected included demographic details such as age, sex, type of visit and clinical diagnoses. Diagnoses were initially recorded using Siddha disease terminology (*Siddha Maruthuvam*, the classical Siddha textbook detailing diseases) and were subsequently mapped to corresponding modern medical terms and National Morbidity Siddha Codes for presentation. In cases of multiple diagnoses, only the primary diagnosis was considered for analysis.

Data entry and data analysis

Clinical data were entered by treating physicians at the time of consultation into the EHR system. Extracted data

were downloaded in Microsoft Excel format for analysis. Age was categorized into predefined groups, and diagnoses were classified according to systems and *Mukkuṭram* (the three humours) for analytical purposes. Variables with missing values were analysed using available-case analysis. The extent of missing data was assessed and reported for each variable (Supplementary Table 1). The data was anonymized by not including the identifiers. Statistical analysis was performed using Epi Info software (version 7.2). Descriptive statistics, including proportions, were used to summarise the morbidity profile.

RESULTS

We collected data from January to December 2024 using the electronic health records (EHR) of Arogya Healthcare Private Limited. During the study period, a total of 28,049 patients visited the outpatient department (OPD), with a monthly average of 2,337 visits. Of all patients, 16,014 (57.1%) were female. The largest age group was 31-45 years, comprising 8,660 patients (31.0%). New patients accounted for 6,977 visits (26.2%), while 1,337 patients (5.1%) utilized online consultation services. Patient volume was highest in November (10.4%) and December (10.3%) and lowest in June (5.7%) (Table 1).

Table 1: Demographic characteristics of patients seeking care in a private siddha facility in Tamil Nadu.

Variables	Frequency	Percent
Age (n=27,946)		
0-15	2,189	7.8
16-30	3,551	12.7
31-45	8,660	31.0
46-60	8,070	28.9
Above 60	5,476	19.6
Gender (n=28,049)		
Female	16,014	57.1
Male	12,033	42.9
Other	2	0.0
Marital status (n=14,253)		
Married	12,365	86.8
Other	186	1.3
Single	1,702	11.9
Visit type (n=26,618)		
Follow-up	18,303	68.8
New	6,977	26.2
Online	1,337	5.0
Humors (Mukkuṭram) n=11,079		
Vali	4,414	40%
Aṣaḥ	3,854	34.7
Aiyam	2,829	25.5

Based on system-wise classification, non-communicable diseases (NCDs) accounted for 2,368 cases (21.4%), followed by musculoskeletal disorders (2,148; 19.4%)

and gastrointestinal tract diseases (1,556; 14%). Together, these three categories contributed to 50% of the overall disease burden (Table 2).

Table 2: Morbidity profile of the patients seeking care in a private Siddha facility in Tamil Nadu.

System wise (n=11,079)	NAMASTE codes	Number (%)
Non-communicable disorders		2,368 (21.4)
Diabetes mellitus		1,380 (12.5)
Hypertension	Z\$12	482 (4.3)
Cancer/neoplasm	P	259 (2.3)
Hyperlipidaemia	-	161 (1.4)
Heart disease	LB	51 (0.5)
Obesity	Z7	35 (0.3)
Musculoskeletal disorders	C	2,148 (19.4)
Osteoarthritis	CAB1.1	816 (7.4)
Lumbar spondylosis	Z34	438 (3.9)
Rheumatoid arthritis	CAA1.3	370 (3.3)
cervical spondylosis	Z37	335 (3.0)
Frozen shoulder	Z11	70 (0.6)
Muscular pain	-	61 (0.5)
Other arthritis	-	58 (0.5)
GIT		1,556 (14.0)
Ulcer	EB	816 (7.3)
Cholelithiasis	-	441 (3.9)
Others	-	279 (2.5)
Diarrhoea/dysentery	EGD1.1/E E	20 (0.2)
Upper respiratory		1,183 (10.7)
Cough/cold	DB / Z73	647 (5.8)
Sinusitis	DD	536 (4.8)
Skin		1,088 (9.8)
Dermatitis	HAA1.1	503 (4.5)
Psoriasis	BD	405 (3.6)
Vitiligo	BI	95 (0.8)
Unknown bite	BEB1.1	61 (0.5)
Ring worm	BQC1.1	24 (0.2)
Infertility		447 (4.0)
Gynecological	G	385 (3.4)
Ano-rectal	R	372 (3.3)
Endocrine disorder	I	342 (3.1)
Lower respiratory	D / TD	340 (3.0)
ENT	H	229 (2.0)
Renal	X	206 (1.8)
Neurological	F	126 (1.1)
Others	-	107 (1.0)
Uro genital	X	101 (0.9)
Lymphatic	-	81 (0.7)

Among patients with recorded diagnoses (n=11,079), we identified diabetes mellitus (1,380; 12.5%) as the most common condition, followed by ulcer (816; 7.4%), osteoarthritis (816; 7.4%), cough (647; 5.9%), sinusitis (536; 4.9%), dermatitis (503; 4.6%), hypertension (482;

4.4%), and infertility (447; 4.0%). We further stratified the top five conditions by age and sex to assess variations in morbidity patterns across demographic groups. Diabetes mellitus ranked as the leading condition in both males and females; however, subsequent disease patterns differed slightly between the sexes. Among females, osteoarthritis (n=595; 9.2%) and ulcer (n=496; 4.6%)

followed diabetes, along with sinusitis (n=311; 4.8%) and cold/cough (n=304; 4.7%). In contrast, among males, cold/cough (n=343; 7.5%) emerged as the second most frequent condition after diabetes, followed by ulcer (n=320; 7.0%), sinusitis (n=224; 4.9%), and osteoarthritis (n=220; 4.8%) (Table 3).

Table 3: Top five diagnoses among both sex patients seeking care in private Siddha facilities in Tamil Nadu.

Male, n=12,033	Number (%)	Female, n=16,014	Number (%)	Total, n=28,049	Number (%)
Diabetes mellitus	667(14.6)	Diabetes mellitus	713 (11)	Diabetes mellitus	1,380 (12.5)
Cold/cough	343 (7.5)	Osteoarthritis	595 (9.2)	Osteoarthritis	816 (7.4)
Ulcer	320 (7)	Ulcer	496 (7.6)	Ulcer	816 (7.4)
Sinusitis	225 (4.9)	Sinusitis	311 (4.8)	Cold/cough	647 (5.8)
Osteoarthritis	221 (4.8)	Cold/cough	304 (4.7)	Sinusitis	536 (4.8)

Age-wise stratification report that distinct differences in health-seeking patterns. The majority of patients below 15 years of age sought care mainly for respiratory conditions such as cold / cough (134; 26.1%), and asthma (116; 22.6%). In the adult age group (16-60 years) and the geriatric population (above 60 years), diabetes was the predominant reason for consultation. This was followed

by ulcer-related conditions among adults and osteoarthritis among the geriatric group. Notably, infertility management (447; 5.6%) also emerged as one of the top five conditions among the adult population, indicating the utilization of Siddha services for reproductive health concerns in addition to chronic disease management (Table 4).

Table 4: Top five diagnosis among each age category seeking care in private Siddha facilities in Tamil Nadu.

Below 15, n=2,189	Number (%)	16-60 years n=20,281	Number (%)	Above 60 n=5,476	Number (%)
Cold/cough	134 (26.1)	Diabetes mellitus	932 (11.7)	Diabetes mellitus	442 (17.3)
Asthma	116 (22.6)	Ulcer	621 (7.8)	Osteoarthritis	339 (13.3)
Sinusitis	54 (10.5)	Osteoarthritis	475 (6)	Ulcer	187 (7.3)
Tonsillitis	46 (8.9)	Sinusitis	457 (5.7)	Hypertension	162 (6.4)
Dermatitis	25 (4.9)	Infertility	447 (5.6)	Lumbar spondylitis	157 (6.2)

DISCUSSION

The present study on morbidity profiling in private Siddha tertiary hospital demonstrates that the majority of patients were middle-aged adults, with a higher proportion of females utilizing OPD services. Diabetes, ulcers, and osteoarthritis were the most frequently reported diagnoses, and nearly one-fifth of the patients sought care for NCDs. A major proportion of vali-related disorders was also observed. Across both sexes, diabetes remained the most prevalent condition, although variations were noted in the distribution of other morbidities. Adult population sought care for chronic diseases like diabetes, osteoarthritis and ulcer. In contrast, children attending the clinics predominantly presented with respiratory illnesses, indicating age-specific differences in disease patterns and service utilization.

Previous morbidity profiling studies conducted in public Siddha facilities have consistently reported musculoskeletal disorders as common morbidity.^{14,15,22,23} In contrast, studies from modern medicine outpatient

settings have reported abdominal pain and knee pain as common morbidities among adults.²⁴ However, the present study showed a different pattern among adults, with non-communicable diseases (NCDs) emerging as the leading category, followed by musculoskeletal disorders, ulcers, and infertility. This observed shift may reflect the ongoing epidemiological transition in India, with a growing burden of chronic and lifestyle-related diseases.²⁵⁻²⁷ At the same time, studies on healthcare-seeking behaviour among individuals with infertility, musculoskeletal disorders, and NCDs have reported that more than 60% of patients preferred private healthcare facilities for treatment.²⁸⁻³⁰ Factors such as urbanization, perceived quality of care, shorter waiting times, and easier accessibility may contribute to this preference for private sector services.³¹ Against this background, the utilisation of Siddha facilities for these conditions in the present study highlights the continued relevance and demand for traditional systems of medicine in managing chronic and long-term health conditions.

Among children, both Siddha and modern medicine studies have reported cold and cough as the most

common reasons for healthcare visits.^{24,32} The pediatric morbidity pattern observed in the present study was consistent with these findings, indicating similar care-seeking trends for common childhood illnesses

Overall, these findings suggest that traditional systems such as Siddha may have a broader role across age groups and disease categories than is often assumed. However, scientific evidences on the outcomes of these treatment and clinical trials on Siddha medicine remain limited.³³ Feedback received from the states under the NAM scheme contributed to the development and budget allocation to Public health activities addressing common morbidities like Musculoskeletal Disorders, maternal health, school children health and NCDs under the State Ayush Mission in Tamil Nadu.^{6,34,35} However, in the absence of morbidity data from private hospitals, these initiatives may have been based largely on information from publicly run hospitals alone. This highlights the need for similar studies from private facilities for policy analysis and interventions.³⁶ Our study findings indicate increasing utilization of private Siddha services for NCDs and chronic diseases, particularly among middle-aged adults, reflecting growing acceptance of traditional medicine. In addition to that, infertility and ulcer also increasing and needs to be addressed through strengthened research and supportive policies.

The lack of comprehensive morbidity studies significantly weakens healthcare systems by generating fragmented and incomplete data, leading to poor clinical documentation and reactive, suboptimal decision-making. Previous studies also indicate that many private Siddha hospitals maintain inadequate patient records, underscoring the urgent need to strengthen digital integration and standardize reporting systems to improve evidence generation in Siddha healthcare. However, government of India initiated various initiatives such as integration of Ayush hospitals with the Ayushman Bharat Digital Mission through the Ayush Grid and establishment of the Ayush Health Management Information System (A-HMIS) for government hospitals using ICD-10/11 improved clinical record-keeping, and facilitate large-scale data analysis and collaborative research.³⁷ Further advancements in digital health infrastructure, including the application of artificial intelligence and machine learning, can enhance data-driven decision-making and improve the quality of care within the Ayush system.³⁸ Therefore, Siddha hospitals must ensure accurate and systematic documentation of patient data to inform policy development, strengthen government initiatives, and ultimately reduce the burden of disease.

This study has certain limitations that should be considered while interpreting the findings. Most of the study clinics were located in urban areas and used one-year data, limiting the generalizability of the findings to private Siddha clinics across the entire state. Despite these limitations, the study provides important baseline

evidence on demographic characteristics and morbidity patterns in private Siddha healthcare settings, an area where published data remain scarce. Further studies are essential to identify existing gaps and improve service delivery. Integrating all Siddha hospitals into a unified system would improve clinical data documentation and support data-driven research and policy-making in the Siddha system of medicine.

CONCLUSION

In 2024, a higher proportion of females attended private Siddha clinics compared to males. The majority of patients sought care for NCDs and musculoskeletal disorders. These findings highlight the need to streamline data collection from private Siddha clinics through a unified electronic database to identify morbidity patterns and support the development of standardised preventive and management strategies for common conditions. Such measures may contribute to reducing the growing burden of chronic diseases in the population.

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