ABSTRACT. The various forms of mortality data and biomedical measures of morbidity have become inadequate measures of the level of health in economically developed countries. Measures of functional physical capacity have some advantages but do not reflect physical impairment. Current attempts to develop sociomedical health indicators include: measures of social disability; typologies of presenting symptoms, which have been used to estimate probable needs for care; measures which focus on behavioral expressions of sickness; research based on operational definitions of 'positive mental health', 'happiness' and perceived quality of life; assessments of met and unmet needs for health care, which are measures of social capacity to care for the sick.

Sociomedical indicators reflect both objective conditions and social values. They are policy-oriented, serving as mobilizing agents for sociopolitical pressures concerned with raising the overall level of health of the population.

The stagnation of total mortality rates over relatively long periods of time in economically developed countries has reduced the value of mortality rates as indicators of the health status of populations in these countries. The insensitivity of mortality rates is quite noticeable in the United States where there is little to suggest that the increase in health services over recent years has resulted in improvements in the level of health. Even the infant mortality rate, long regarded as the most sensitive index of the level of health, is no longer a particularly useful indicator, despite the fact that the infant mortality rate of the United States suffers in comparison to that of many industrial nations [13]. The principal residual value of infant death rates is to reveal contrasts in health status within limited geographic areas as in large cities, as exemplified by a recent analysis in New York City [27]. Mortality rates are also useful for the assessment of specific diseases, but the present behavior of mortality rates have made moot the value of statistics of deaths from all causes as a measure of health in countries like the United States. The usefulness of biomedical indicators for population-based measures of health status is declining.
Nearly two decades ago (1957) the World Health Organization [32] recommended that mortality data in various forms – life expectancy at birth, the infant mortality rate, the crude death rate and the proportionate mortality rate for ages fifty years and over – be used as indicators of level of living for international comparison. The great virtue of mortality data is the availability of a long and generally comparable series of statistics. There is, as yet, no other body of routine statistics that provides diagnostic data for a country as a whole. Indeed, a principal reason for the WHO recommendation is that mortality data are available for many countries.

The inadequacies of mortality data have been summarized by Moriyama [33] as follows:

- In countries where the need for statistical information is greatest the data are non-existent or of poor quality.
- While high lethality conditions, e.g., lung cancer are well represented, nonfatal conditions, e.g., arthritis, do not have the same probability of appearing in the statistics.
- The relationship of mortality and morbidity has not been clear.
- As chronic non-infective disease has increased, the interpretation of mortality statistics has become more difficult, particularly in cases of multiple, potentially fatal, chronic conditions.

It is paradoxical but what has been the most successful international effort in developing uniform statistics with respect to mortality, the World Health Organization’s publications of *International Classification of Diseases, and Causes of Death* [21], now in its eighth revision, has inhibited, if not stultified, the development of non-lethal measures of the health status of populations.

The inadequacy of and dissatisfaction with mortality rates as a measure of health level have led to demands for morbidity rates and “even other measures of social well being” [29]. It is useful to distinguish between biomedical and sociomedical measures of morbidity. Biomedical measures of morbidity include [17]:

1. Tissue alterations, viewed as such and judged by pathologists to be causes of death – e.g., ‘atherosclerosis’, ‘carcinoma’.
2. Records produced by physiologic measuring equipment – e.g., the electrocardiogram; and the interpretations by specialists – e.g., cardiologists – of such records as the ‘right bundle branch block’.