# **Analysis of Mortality-Based Global Health Metrics: A Principle Component Analysis (PCA) – K-Means Approach to Country-Level Data**

Güler Önder **¹** , Yeter Uslu **¹** , Ümran Tüzün **²** & Emrah Önder **²**

<sup>1</sup> Department of Health Management, School of Health Sciences, Medipol University, İstanbul, Türkiye

² Department of Quantitative Methods, School of Business, İstanbul University, İstanbul, Türkiye

#### **Abstract**

In this study, principal component analysis and the k-means algorithm were employed for the analysis of Mortality-Based Global Health Metrics. The aim of this study is to create homogeneous clusters of countries in terms of Mortality-Based Global Health Metrics, to identify similar countries within clusters using withincluster exploratory data analysis methods, and to investigate the common characteristics of these countries. At the country level, a dataset comprising 34 indicators was compiled. However, due to the curse of dimensionality inherent in machine learning, the dataset was reduced to 6 principal components through principal component analysis (PCA). Countries were then clustered into 6 groups using the K-means clustering analysis method. The elbow method and silhouette method were utilized for optimal cluster selection. The cluster information resulting from dimensionality reduction analysis and clustering analysis can serve as a valuable input for policymakers in healthcare, particularly regarding cluster centroids and the countries constituting each cluster. Healthcare policymakers for each country can develop much more rational policies in their decision-making processes by evaluating their own countries, other countries within the same cluster, the characteristic features of their own clusters, and the distances to successful cluster centroids. This enables better examination of positive and negative indicators in country comparisons.

**Keywords** Health, Mortality, World Development Indicators, Principal Component Analysis, Clustering

**Jel Codes** C38, I18, O57

#### **Contents**





#### C Correspondence

E. Önder [emrah@istanbul.edu.tr](mailto:emrah@istanbul.edu.tr)

#### Timeline



#### Copyright

2024. Önder, G., Uslu, Y., Tüzün, Ü. & Önder, E.

#### License

This work is licensed under Creative Commons Attribution-NonCommercial 4.0 International License. @ 1

#### 99 Citation

Önder, G., Uslu, Y., Tüzün, Ü. & Önder, E. (2024). Analysis of Mortality-Based Global Health Metrics: A Principle Component Analysis (PCA) – K-Means Approach to Country-Level Data, *alphanu meric*, 12 (2), 75-106. [https://doi.org/10.](https://doi.org/10.17093/alphanumeric.1548227) [17093/alphanumeric.1548227](https://doi.org/10.17093/alphanumeric.1548227)

# <span id="page-1-0"></span>**1. Introduction**

In order to holistically improve health and reduce preventable deaths in countries, it may be useful for academics, researchers and decision-makers in governments to subdivide the world into homogeneous groups according to causes of mortality in order to manage the problem in smaller pieces. Investigating the concentration of certain types of mortality in certain regions of the world can help guide the development of macro-scale health policies. One of the most important functions of the health systems of countries is to protect the physical and mental health integrity of their citizens who benefit from this system and to extend their life span by reducing preventable deaths. By facilitating access to hospitals and achievements in the diagnosis and treatment of mental illnesses, it is possible to reduce suicide rates in countries. As the economic development of countries increases, the budget allocated to the health system may increase. This facilitates hospital access and reduces preventable deaths. Mortality rates are among the quality metrics of healthcare services in countries [\(Kelley & Hurst, 2006](#page-10-1)). One of the most important criteria used to compare the health levels of countries is the mortality criteria. It is important to know the cause and manner of death of people living in a country in order to provide, evaluate and plan health services [\(Hayran & Ozbek,](#page-10-2) [2017\)](#page-10-2). In this context, the situation of the countries of the world can be examined by expanding the mortality dimension, which is among the health services quality metrics, and addressing subvariables. Survival to age 65, life expectancy at birth, mortality from cardiovascular diseases (CVD), cancer, diabetes, maternal mortality rate or chronic respiratory diseases (CRD) between ages 30 and 70, mortality rate, maternal mortality rate, infant mortality, number of deaths under the age of five, etc., are among the crucial mortality-based indicators of countries' healthcare quality performance. The aim of this study is to identify countries with similar structures in terms of mortality-based global health metrics. In this context, k-means cluster analysis was used to find homogenous country groups. Due to the large number of variables, the efficiency of cluster analysis was increased by applying dimension reduction analysis with a 95% explained variance threshold before cluster analysis. In the relevant years, six main components with values above this threshold were observed. Primary care, cancer care, acute care, end-of-life care, mental health care, patient safety, patient experiences, prescribing in primary care, integrated care are some of the dimensions of health care quality in countries. These dimensions have dozens of subcategories. However, in this article, the rates of mortality types, survival and life expectancy at birth, which are important outputs of all these dimensions, will be discussed and countries will be clustered according to their healthcare levels. Data Compiled from World Development Indicators (WDI) database. World Development Indicators is a compilation of 1,400 time series indicators from 217 countries on global development and poverty reduction. In this study, 34 variables from 196 countries were utilized.

### <span id="page-1-1"></span>**2. Literature Review**

According to the World Health Organization (WHO), cancer is the second leading cause of death worldwide, accounting for one in every six deaths and killing an estimated 9.6 million people in 2018. The burden of cancer is increasing worldwide, and it is difficult for health systems, especially in low-and middle-income countries, to manage this increasing burden due to limited access to early diagnosis and treatment. Alcohol consumption causes 2.6 million deaths and worsens the health of billions of people annually and increases the global burden of disease. Alcohol use is a major risk factor for premature death and disability, particularly in people aged 20 to 39 years, accounting for 13% of deaths in this age group. Cardiovascular diseases are the leading cause of death, killing an estimated 17.9 million people worldwide each year. One third of deaths from cardiovascular disease (CVD) occur in people under the age of 70, leading to premature death. In CVDs, especially in primary health care services, identifying people at risk and ensuring their access to treatment is important in terms of preventing early deaths. According to World Health Organization data, the number of deaths of children under 5 years of age has halved between 2000 and 2017 thanks to the initiatives implemented. Despite these positive results, child mortality can be significantly prevented by ensuring access to health services, improving living conditions and reducing environmental risk factors. Especially in developing countries, adverse environmental conditions and pollution cause an increase in child mortality ([WHO, 2024\)](#page-11-1).

Hedegaard et al. analyzed deaths from suicide in the USA in their study in 2021. In this academic article, they emphasized that suicide was the second most important cause of death among deaths in the 10-34 age group in the USA for 2019 ([Hedegaard, 2021\)](#page-10-3). In the academic study of Bizzego et al. in 2021, the causes of under-5 child mortality in low- and middle-income countries were analyzed with machine learning methods. Among the findings of this study is the necessity to reduce the under-five mortality rate by discouraging "geriatric primiparity," improving the education of household heads, enhancing family welfare, improving housing conditions (focusing on cooking fuels, toilet facilities, refrigeration, and drinking water), and reducing family size and household overcrowding ([Bizzego et](#page-10-4) [al., 2021](#page-10-4)). According to UNICEF reports, under the framework of the Sustainable Development Goals, the aim is to end preventable deaths of newborns and children under 5 years of age by 2030. The goal is for all countries to reduce the neonatal mortality rate to at least 12 deaths per 1,000 live births and the under-5 mortality rate to at least 25 deaths per 1,000 live births [\(UNICEF, 2023\)](#page-10-5). In their 2020 study, Cheng et al. examined the impact of population aging on mortality rates for 195 countries/ regions and 169 causes of death. In this study, it was found that population aging was associated with significant changes in the number of deaths between 1990 and 2017. However, the attributed mortality rate varied substantially across income levels, countries, and causes of death. Additionally, the two largest contributors to disease-specific deaths globally due to population aging between 1990 and 2017 were identified as ischemic heart disease and stroke [\(Cheng et al., 2020\)](#page-10-6). [Victora et al.](#page-11-2) [\(2020\)](#page-11-2) conducted a study in which they analyzed the relationship between ethnicity and the mortality rate for children under the age of five using data obtained from demographic surveys across 36 lowand middle-income countries ([Victora et al., 2020\)](#page-11-2). In 2023, Liang et al. reviewed academic literature on a wide range of mortality indicators relevant for measuring health system performance in highincome countries. The findings suggest that premature mortality indicators are important variables for measuring both public health and health system performance ([Liang et al., 2023](#page-10-7)). Ward et al. examined cause-based maternal mortality rates across countries in 2023 and built a simulation and forecasting model for the period 1990-2050. According to this study, even if there is a decrease in maternal mortality rates over the years, this decrease does not come close to the Sustainable Development Goal targets ([Ward et al., 2023\)](#page-11-3). In 2014, Sartorius et al. conducted a comprehensive analysis of infant mortality rates (IMRs) across 192 countries for the period from 1990 to 2011. The study's findings reveal that Sub-Saharan Africa (SSA) has the highest infant mortality rates globally. Furthermore, the research identifies maternal mortality (survival), insufficient access to water and sanitation, and female education as critical determinants significantly contributing to elevated IMR ([Sartorius & Sartorius, 2014](#page-10-8)). The same region (Sub-Saharan Africa) was also studied by Kayode et al. in 2017. In this study, differences in the quality of health service management, HIV prevalence

and socioeconomic deprivation were identified as factors explaining the differences in neonatal mortality rates observed in countries in this region [\(Kayode et al., 2017\)](#page-10-9). The 2006 study by Kelley and Hurst aims to provide a conceptual framework for the OECD's Health Care Quality Indicator (HCQI) Project. The study examined the concepts and dimensions of health care quality [\(Kelley & Hurst,](#page-10-1) [2006](#page-10-1)). When academic studies are analyzed, it can be seen that the infant mortality rate (IMR) health indicator is one of the important quality metrics of public health ([Sartorius & Sartorius, 2014\)](#page-10-8).

# <span id="page-3-0"></span>**3. Methodology**

The analysis utilized two unsupervised machine learning algorithms in a hybrid approach. Due to the large number of variables, which posed the curse of dimensionality problem, principal component analysis (PCA) was initially applied to reduce the dimensionality of the variables. Clustering algorithms tend to decrease in performance as the number of dimensions increases. Therefore, PCA, employed as a precursor, positively contributes to the performance of clustering analysis.

There are many advantages of applying principal component analysis before cluster analysis, especially when working with a large number of variables. Some of these advantages include reduction of cluster analysis processing time and computational burden, more homogeneous contribution of transformed variables to cluster analysis, more reliable clustering results, reduction of noise and redundant variables distorting cluster analysis, more distinct clusters and more meaningful cluster centers ([Odong et al., 2013](#page-10-10); [Ros & Riad, 2024](#page-10-11); [Sanguansat, 2012](#page-10-12)).

### <span id="page-3-1"></span>**3.1. Dimensionality Reduction**

Dimension reduction is one of the algorithms of unsupervised machine learning. It helps to transform the dataset from its complex structure into a simpler form. In this process, a condensed set of new features is created based on the original features of the dataset ([Ros & Riad, 2024\)](#page-10-11).

### **3.1.1. Principle Component Analysis (PCA)**

The process of principal component analysis begins with the computation of covariances for all columns (features) and storing these values in a matrix structure. This initial step encapsulates the information about how each variable is related to others. This matrix structure can then be used to find eigenvectors, which represent the directions of data distribution, and eigenvalues, which indicate the magnitude of importance along each eigenvector [\(Pajankar & Joshi, 2022\)](#page-10-13).

By creating new features with minimal information loss from the original features, we reduce the high-dimensional space to a lower-dimensional space. The new features are called principal components and each principal component is orthogonal to each other. This captures different aspects of the dataset characteristics. The first few principal components often represent a significant proportion of the variance explained, preserving an important part of the information. Principal Component Analysis (PCA) is a powerful technique to help reduce the size of the data [\(Ros & Riad, 2024](#page-10-11)).

### <span id="page-3-2"></span>**3.2. Clustering Analysis**

Cluster analysis is the process of partitioning a dataset consisting of units (observations) and variables (features) into useful clusters, maximizing the homogeneity within clusters of units with each other and the heterogeneity with other cluster units [\(Ramasubramanian & Singh, 2019](#page-10-14)).

#### **3.2.1. K-Means Algorithm**

The K-Means algorithm is an algorithm that groups units into k clusters based on their attributes. K is a positive integer that can be found using various methods to determine the most suitable value. While finding the optimal clusters, the sum of the squared distances between the data and the corresponding vector set is minimized. In this way, homogeneous clusters are found, and relatively close units are identified. During the steps of the algorithm, cluster centers are updated in each iteration [\(Mohbey & Bakariya, 2022](#page-10-15)).

The steps of the K-Means algorithm are as follows ([Vasques, 2024](#page-10-16)):

- 1. Determination of the number of clusters
- 2. K cluster centers are randomly selected
- 3. Using a specific distance metric (Euclidean, Manhattan, Minkowski, etc.), observations are assigned to the nearest center point.
- 4. For each cluster, the weight centers are updated according to the average of the observations within the cluster.
- 5. Repeat steps 3 and 4 until convergence is reached as measured by a threshold for minimum change in cluster center position.

# <span id="page-4-0"></span>**4. Data Set, Application and Findings**

### <span id="page-4-1"></span>**4.1. Dataset and Preprocess**

Survival to age 65, life expectancy at birth, mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70 (%), mortality rate attributed to household and ambient air pollution, mortality rate attributed to unintentional poisoning, mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene, adult mortality rate, infant mortality rate, neonatal mortality rate, under-5 mortality rate, probability of dying among adolescents ages, probability of dying among children ages 5-9 years, probability of dying among youth ages 20-24 years, completeness of infant death reporting, completeness of total death reporting, probability of dying at age 5-14 years and suicide mortality rate are some of the variables in this analysis. The World Development Indicators [\(Knoema,](#page-10-17) [2024](#page-10-17); [World Bank, 2024](#page-11-4)) database was used to compile the dataset.

| <b>Series</b>     | Series Name  |
|-------------------|--|
| SP.DYN.TO65.FE.ZS | Survival to age 65, female (% of cohort)   |
| SP.DYN.TO65.MA.ZS | Survival to age 65, male (% of cohort)   |
| SP.DYN.LEOO.FE.IN | Life expectancy at birth, female (years)   |
| SP.DYN.LE00.MA.IN | Life expectancy at birth, male (years)   |
| SP.DYN.LEOO.IN    | Life expectancy at birth, total (years)  |
| SH.DYN.NCOM.ZS    | Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70 (%)                                   |
| SH.DYN.NCOM.FE.ZS | Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70, female (%)                           |
| SH.DYN.NCOM.MA.ZS | Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70, male (%)                             |
| SH.STA.AIRP.P5    | Mortality rate attributed to household and ambient air pollution, age-standardized (per 100,000<br>population) |

**Table 1.** Variables and Their Definitions



### <span id="page-5-0"></span>**4.2. Principal Component Analysis**

The complex data set was simplified by principal component analysis. The curse of dimensionality is avoided, and the performance of the clustering algorithm is improved. As a result of the principal components analysis, the explained variance values for all years within the scope of the analysis are 0.97007 for 2015, 0.97171 for 2016, 0.96780 for 2017, 0.96698 for 2018 and 0.95751 for 2019 as seen in [Table 2.](#page-6-0)

<span id="page-6-0"></span>

| <b>Principal Components</b>   | Explained Variance of Principal Component by Years |         |         |         |         |  |
|-------------------------------|--|---------|---------|---------|---------|--|
|                               | 2015   | 2016    | 2017    | 2018    | 2019    |  |
| pc1                           | 0,70401  | 0,70106 | 0,70365 | 0,70080 | 0,70441 |  |
| pc <sub>2</sub>               | 0,14189  | 0,14160 | 0,13336 | 0,13336 | 0,11989 |  |
| pc3                           | 0,05469  | 0.05652 | 0,05907 | 0.05905 | 0,06162 |  |
| pc4                           | 0.03419  | 0,03559 | 0,03427 | 0.03671 | 0.03311 |  |
| pc5                           | 0,02239  | 0.02394 | 0,02438 | 0,02402 | 0,02734 |  |
| pc6                           | 0,01291  | 0,01300 | 0.01307 | 0,01306 | 0.01116 |  |
| Cumulative Explained Variance | 0,97007  | 0.97171 | 0,96780 | 0.96698 | 0.95751 |  |

**Table 2.** Cumulative Explained Variance in Principal Component Analysis

When the relationship (loadings) of each principal component (PC) with the original variables is analyzed, it can be observed that the variables that affect PC1 the most are the following. The loadings of the first four variables are positive, meaning that an increase in the value of these variables leads to an increase in the value of PC1. The next four variables have negative loadings. In other words, an increase in the value of these variables leads to a decrease in the value of PC1.

- ‣ **SP.DYN.IMRT.MA.IN:** Mortality rate, infant, male (per 1,000 live births)
- ‣ **SP.DYN.IMRT.IN:** Mortality rate, infant (per 1,000 live births)
- ‣ **SH.DYN.MORT.MA:** Mortality rate, under-5, male (per 1,000 live births)
- ‣ **SP.DYN.IMRT.FE.IN:** Mortality rate, infant, female (per 1,000 live births)
- ‣ **SP.DYN.LE00.MA.IN:** Life expectancy at birth, male (years)
- ‣ **SP.DYN.TO65.FE.ZS:** Survival to age 65, female (% of cohort)
- ‣ **SP.DYN.LE00.IN:** Life expectancy at birth, total (years)
- ‣ **SP.DYN.LE00.FE.IN:** Life expectancy at birth, female (years)

The variables that affect PC2 the most are listed below. While the first ten variables have positive loadings, the last three variables have negative loadings. In particular, the loadings of suicide-related variables in PC2 are relatively very high.

- ‣ **SH.STA.SUIC.MA.P5:** Suicide mortality rate, male (per 100,000 male population)
- ‣ **SH.STA.SUIC.P5:** Suicide mortality rate (per 100,000 population)
- ‣ **SH.STA.SUIC.FE.P5:** Suicide mortality rate, female (per 100,000 female population)
- ‣ **SH.DYN.NCOM.MA.ZS:** Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70, male (%)
- ‣ **SH.DYN.NCOM.ZS:** Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70 (%)
- ‣ **SH.STA.POIS.P5.MA:** Mortality rate attributed to unintentional poisoning, male (per 100,000 male population)
- ‣ **SH.STA.POIS.P5:** Mortality rate attributed to unintentional poisoning (per 100,000 population)
- ‣ **SH.DYN.NCOM.FE.ZS:** Mortality from CVD, cancer, diabetes or CRD between exact ages 30 and 70, female (%)
- ‣ **SP.DYN.AMRT.MA:** Mortality rate, adult, male (per 1,000 male adults)
- ‣ **SH.STA.POIS.P5.FE:** Mortality rate attributed to unintentional poisoning, female (per 100,000 female population)
- ‣ **SH.DYN.0514:** Probability of dying at age 5-14 years (per 1,000 children age 5)
- ‣ **SH.DYN.0509:** Probability of dying among children ages 5-9 years (per 1,000)

‣ **SH.DYN.1014:** Probability of dying among adolescents ages 10-14 years (per 1,000)

#### <span id="page-7-0"></span>**4.3. Clustering Algorithm**

Elbow and silhouette methods were used to determine the optimal number of clusters. The optimal number of clusters for the years 2015, 2016, 2017, 2018 and 2019 included in the analysis was determined as 6. An interesting result of the clustering analyses conducted separately for the five years is that the sixth cluster consists of only one country in all five analyses. This country is Lesotho.

| Years | Clusters  |           |           |           |           |           |  |  |  |
|-------|-----------|-----------|-----------|-----------|-----------|-----------|--|--|--|
|       | Cluster 1 | Cluster 2 | Cluster 3 | Cluster 4 | Cluster 5 | Cluster 6 |  |  |  |
| 2015  | 56        | 67        | 19        | 31        | 22        | 1         |  |  |  |
| 2016  | 56        | 66        | 18        | 33        | 22        | 1         |  |  |  |
| 2017  | 63        | 62        | 18        | 33        | 19        | 1         |  |  |  |
| 2018  | 55        | 68        | 18        | 35        | 19        | 1         |  |  |  |
| 2019  | 57        | 64        | 21        | 34        | 19        | 1         |  |  |  |

**Table 3.** Cumulative Explained Variance in Principal Component Analysis

### <span id="page-7-1"></span>**4.4. Findings**

When the findings are analyzed, life expectancy at birth for 2015 is as follows: 80.07 years for cluster 1 (with a standard deviation of 2.36 years), 73.35 years for cluster 2 (with a standard deviation of 2.70 years), 68.69 years for cluster 3 (with a standard deviation of 3.45 years), 63.96 years for cluster 4 (with a standard deviation of 2.07 years), 57.62 years for cluster 5 (with a standard deviation of 2.80 years) and 51.10 years for cluster 6 (standard deviation is zero as it consists of a single country).

While assigning cluster IDs to the clusters formed as a result of k-means analysis, SP.DYN.LE00.IN (life expectancy at birth, total (years)) was utilized. In each 5-year period, cluster 1 ID was assigned to the cluster with the highest life expectancy at birth and cluster 6 ID was assigned to the cluster with the lowest life expectancy at birth.

For 2015, mortality rates for children under 5 years of age are inversely correlated with life expectancy at birth. Only cluster 5 and cluster 6 are in the opposite order in this context. Under-5 mortality per 1000 live births is 5.40 (st. dev. 2.88) for cluster 1, 19.42 (st. dev. 8.68) for cluster 2, 23.57 (st. dev. 13.96) for cluster 3, 56.42 (st. dev. 10.57) for cluster 4, 100.32 (st. dev. 22.07) for cluster 5 and 82.50 for cluster 6.

There are 54 countries that were in cluster 1 for five years between 2015 and 2019 included in the analysis. These countries are as follows: Albania, Andorra, Australia, Austria, Bahrain, Israel, Uruguay, Belgium, Bosnia and Herzegovina, Canada, United States of America, United Arab Emirates, Chile, Costa Rica, China, Cuba, Croatia, Ecuador, Cyprus, Czechia, Denmark, Turks and Caicos Islands, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Kuwait, Italy, Japan, Malta, Luxembourg, Maldives, Sri Lanka, Qatar, Monaco, Montenegro, Netherlands, New Zealand, Norway, Poland, Portugal, San Marino, Slovakia, Singapore, Slovenia, Spain, South Korea, Sweden, Switzerland, United Kingdom.

There are 19 countries that were in cluster 5 for five years between 2015 and 2019 included in the analysis. These countries are as follows: Angola, Benin, Burkina Faso, Cameroon, Central African

Republic, Chad, Dem. Rep. Congo, Cote d'Ivoire, Eq. Guinea, Guinea, Guinea-Bissau, Liberia, Mali, Mozambique, Niger, Nigeria, Sierra Leone, Somalia, South Sudan. The map of the African continent below illustrates the 19 countries that consistently remained in cluster 5 over a five-year period, as well as Lesotho, which persistently stayed in cluster 6 without any changes during the same timeframe ([Figure 1](#page-8-0)).

<span id="page-8-0"></span>

Note: The website www.geograf.in was used to create the image ([Geograp.IN, 2024\)](#page-10-18). **Figure 1.** Representative image of the locations of the countries in Cluster 5 and Cluster 6 with their flags.

There were no countries from outside the African continent in cluster 5 and cluster 6 for the relevant 5 years. Only 9 of the 29 countries in cluster 4 during the relevant 5 years were outside the African continent. These countries can be listed as follows: Lao PDR (Asia), Marshall Islands (Oceania), Myanmar (Asia), Papua New Guinea (Oceania), Timor-Leste (Asia), Haiti (North America - Caribbean), Yemen (Asia), Afghanistan (Asia) and Pakistan (Asia).

Cluster 1 is characterized by the highest survival to age 65 for both men and women, as well as the highest life expectancy at birth for women, men and overall. Cluster 1, which has the lowest value in other mortality-based variables, shows a different structure in suicide variables. Cluster 1 ranks 3rd after Cluster 6 and Cluster 3 in the variables of female, male and overall suicide mortality rate.

Cluster 2 has the second highest survival to age 65 for both men and women, as well as the second highest life expectancy at birth for women, men and men in general. It has the second lowest values for other mortality-based variables. The most characteristic feature of Cluster 2 is that it has the lowest value for female, male and overall suicide mortality variables. Turkey is a country in cluster 2 in 2015, 2016, 2018 and 2019. Turkey was only in cluster 1 in 2017.

Cluster 3 has the third highest survival to age 65 for both men and women, as well as the third highest life expectancy at birth for women, men and overall. The most characteristic feature of cluster 3 is that it is second only to cluster 6 in the mortality rate from cardiovascular diseases, cancer, diabetes or chronic respiratory disease between the ages of 30 and 70, for women, men and overall. In addition, the mortality rate due to unintentional poisoning in men has the second highest value after cluster 6. Cluster 3 has the third lowest values in other mortality rates and the second highest suicide rates after Cluster 6.

Cluster 4 has the fourth highest survival to age 65 for both men and women and the third highest life expectancy at birth for women, men and overall. Cluster 4 has the fourth highest values for other mortality variables.

Cluster 5 and Cluster 6 have the lowest survival to age 65 for both men and women, as well as the lowest life expectancy at birth for women, men and overall. Cluster 6 has higher values than Cluster 5 for most mortality variables, while Cluster 5 averages are higher than Cluster 6 averages for infant mortality rate.

Cluster 6 consists of only one country. This country is Lesotho. Lesotho has by far the highest suicide death rate for both men and women in the world. The other three countries with very high female suicide rates are Guyana, South Korea and the Federated States of Micronesia. The countries with very high male suicide rates are Guyana, Eswatini, Kiribati, Lithuania and the Russian Federation.

The countries with the highest mortality rates from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases in women aged 30-70 years are: Kiribati, Federated States of Micronesia, Lesotho, Afghanistan and Solomon Islands. The countries with the highest mortality rates from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases in men aged 30-70 years are: Kiribati, Federated States of Micronesia, Lesotho, Eswatini and Mongolia. Argentina and Serbia are the countries that have experienced the most displacement between cluster 1 and cluster 2 over the years. Cluster 2 has the lowest suicide rate. Cluster 6 (Lesotho) and cluster 3 have the highest suicide rates.

# <span id="page-9-0"></span>**5. Conclusion and Suggestions**

The distribution by continents of the countries forming cluster 1, which have the lowest mortality rates and the highest life expectancy at birth, is as follows: Europe: 59.26%, Asia: 22.22%, North America: 9.26%, South America: 5.56%, Oceania: 3.70%. The countries in cluster 5 and cluster 6, which have the highest mortality rates and the lowest life expectancy at birth, are all in Africa.

Causality analyses can be made in the findings of this study. Lesotho, which constitutes a single cluster, can be scrutinized and its characteristics can be analyzed multidimensionally. Dimensions such as the geographical structure of the country, its economic situation, intensive occupational fields, access to health services, psychological conditions of its citizens, eating habits, genetic

structures, etc. can be analyzed. Relationships between countries in clusters and types of diseases can be examined. The findings and causality results can be integrated with the policies of the World Health Organization, thus improving data-driven decision-making processes.

# **Declarations**

**Conflict of interest** The authors have no competing interests to declare that are relevant to the content of this article. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. You may not use the material for commercial purposes. The images or other third party material in this article are included in the article's Creative Commons licence unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit <https://creativecommons.org/licenses/by-nc/4.0/>.

### <span id="page-10-0"></span>**References**

- <span id="page-10-4"></span>Bizzego, A., Gabrieli, G., Bornstein, M. H., Deater-Deckard, K., Lansford, J. E., Bradley, R. H., Costa, M., & Esposito, G. (2021). Predictors of Contemporary under-5 Child Mortality in Low- and Middle-Income Countries: A Machine Learning Approach. *International Journal of Environ mental Research and Public Health*, *18*(3), 1315. https:// doi.org/[10.3390/ijerph18031315](https://doi.org/10.3390/ijerph18031315)
- <span id="page-10-6"></span>Cheng, X., Yang, Y., Schwebel, D. C., Liu, Z., Li, L., Cheng, P., Ning, P., & Hu, G. (2020). Population ageing and mortality during 1990–2017: A global decomposition analysis. *PLOS Medicine*, *17*(6), e1003138. https://doi.org[/10.1371/](https://doi.org/10.1371/journal.pmed.1003138) [journal.pmed.1003138](https://doi.org/10.1371/journal.pmed.1003138)
- <span id="page-10-18"></span>Geograp.IN. (2024, March). *Color the map*. Matika.in z. s. <https://www.geograf.in/en/map-color.php>
- <span id="page-10-2"></span>Hayran, O., & Ozbek, H. (2017). *Sag\ul ık bilimlerinde aras\ct ırma ve istatistik yontemler* ((SPSS uygulama ornekleri ile genis\cletilmis 2. baskı).). Istanbul.
- <span id="page-10-3"></span>Hedegaard, H. (2021). *Suicide Mortality in the United States, 19992019*. https://doi.org/[10.15620/cdc:101761](https://doi.org/10.15620/cdc:101761)
- <span id="page-10-9"></span>Kayode, G. A., Grobbee, D. E., Amoakoh-Coleman, M., Ansah, E., Uthman, O. A., & Klipstein-Grobusch, K. (2017). Variation in neonatal mortality and its relation to country characteristics in sub-Saharan Africa: an ecological study. *BMJ Global Health*, *2*(4), e209. https://doi.org[/10.](https://doi.org/10.1136/bmjgh-2016-000209) [1136/bmjgh-2016-000209](https://doi.org/10.1136/bmjgh-2016-000209)
- <span id="page-10-1"></span>Kelley, E., & Hurst, J. (2006). https://doi.org[/10.1787/](https://doi.org/10.1787/440134737301) [440134737301](https://doi.org/10.1787/440134737301)
- <span id="page-10-17"></span>Knoema. (2024, March). *World Development Indi cators*. Knoema. [https://public.knoema.com/lftihvf/](https://public.knoema.com/lftihvf/world-development-indicators-wdi) [world-development-indicators-wdi](https://public.knoema.com/lftihvf/world-development-indicators-wdi)
- <span id="page-10-7"></span>Liang, C. Y., Kornas, K., Bornbaum, C., Shuldiner, J., De Prophetis, E., Buajitti, E., Pach, B., & Rosella, L. C. (2023). Mortality-based indicators for~measuring health system performance and~population health in~high-

income countries: a systematic review. *IJQHC Communi cations*, *3*(2). https://doi.org/[10.1093/ijcoms/lyad010](https://doi.org/10.1093/ijcoms/lyad010)

- <span id="page-10-15"></span>Mohbey, K. K., & Bakariya, B. (2022). *An Introduction to Python Programming*. BPB Publications.
- <span id="page-10-10"></span>Odong, T. L., Heerwaarden, J. van, Hintum, T. J. L. van, Eeuwijk, F. A. van, & Jansen, J. (2013). Improving Hierarchical Clustering of Genotypic Data via Principal Component Analysis. *Crop Science*, *53*(4), 1546–1554. https:// doi.org[/10.2135/cropsci2012.04.0215](https://doi.org/10.2135/cropsci2012.04.0215)
- <span id="page-10-13"></span>Pajankar, A., & Joshi, A. (2022). *Hands-on Machine Learning with Python: Implement Neural Network Solutions with Scikitlearn and PyTorch*. Apress. https://doi.org/ [10.1007/978-1-4842-7921-2](https://doi.org/10.1007/978-1-4842-7921-2)
- <span id="page-10-14"></span>Ramasubramanian, K., & Singh, A. (2019). *Machine Learning* Using R: With Time Series and Industry-Based Use Cases *in R*. Apress. https://doi.org[/10.1007/978-1-4842-4215-5](https://doi.org/10.1007/978-1-4842-4215-5)
- <span id="page-10-11"></span>Ros, F., & Riad, R. (2024). *Feature and Dimensionality Reduc tion for Clustering with Deep Learning*. Springer Nature Switzerland. https://doi.org/[10.1007/978-3-031-48743-9](https://doi.org/10.1007/978-3-031-48743-9)
- <span id="page-10-12"></span>Sanguansat, P. (2012). *Principal Component Analysis - Multidisciplinary Applications*. InTech. https://doi.org[/10.](https://doi.org/10.5772/2694) [5772/2694](https://doi.org/10.5772/2694)
- <span id="page-10-8"></span>Sartorius, B. K., & Sartorius, K. (2014). Global infant mortality trends and attributable determinants – an ecological study using data from 192 countries for the period 1990– 2011. *Population Health Metrics*, *12*(1). https://doi.org/ [10.1186/s12963-014-0029-6](https://doi.org/10.1186/s12963-014-0029-6)
- <span id="page-10-5"></span>UNICEF. (2023). *Levels and Trends in Child Mortality* (Issue Report2023).
- <span id="page-10-16"></span>Vasques, X. (2024). *Machine Learning Theory and Applica* tions: Hands-on Use Cases with Python on Classical *and Quantum Machines*. Wiley. https://doi.org[/10.1002/](https://doi.org/10.1002/9781394220649) [9781394220649](https://doi.org/10.1002/9781394220649)
- <span id="page-11-2"></span>Victora, C. G., Barros, A. J. D., Blumenberg, C., Costa, J. C., Vidaletti, L. P., Wehrmeister, F. C., Masquelier, B., Hug, L., & You, D. (2020). Association between ethnicity and under-5 mortality: analysis of data from demographic surveys from 36 low-income and middle-income countries. *The Lancet Global Health*, *8*(3), e352–e361. https:// doi.org/[10.1016/s2214-109x\(20\)30025-5](https://doi.org/10.1016/s2214-109x(20)30025-5)
- <span id="page-11-3"></span>Ward, Z. J., Atun, R., King, G., Sequeira Dmello, B., & Goldie, S. J. (2023). Simulation-based estimates and projections of global, regional and country-level maternal mortality by cause, 1990–2050. *Nature Medicine*, *29*(5), 1253–1261. https://doi.org/[10.1038/s41591-023-02310-x](https://doi.org/10.1038/s41591-023-02310-x)
- <span id="page-11-1"></span>WHO. (2024, August). *Cancer*. World Health Organization. [https://www.who.int/health-topics/cancer/#tab=](https://www.who.int/health-topics/cancer/#tab=tab\_1)  $tab\1$
- <span id="page-11-4"></span>World Bank. (2024, March). *The World Development Indi cators*. The World Bank. [https://datatopics.worldbank.](https://datatopics.worldbank.org/world-development-indicators/) [org/world-development-indicators/](https://datatopics.worldbank.org/world-development-indicators/)

# <span id="page-11-0"></span>**Appendix**



#### **Appendix 1.** Clusters and Countries within the Clusters for the Year 2015



# **Appendix 2.** Mean and Standard Deviation Values of Variables by Clusters for the Year 2015







**Appendix 3.** Determination of the Optimal Number of Clusters for the Year 2015

**Appendix 4.** Representation of Countries by Clusters on the World Map for the Year 2015





**Appendix 5.** Box Plots of Clusters by Variables for the Year 2015

**Appendix 6.** Clusters and Countries within the Clusters for the Year 2016





### **Appendix 7.** Mean and Standard Deviation Values of Variables by Clusters for the Year 2016







**Appendix 8.** Determination of the Optimal Number of Clusters for the Year 2016

**Appendix 9.** Representation of Countries by Clusters on the World Map for the Year 2016





**Appendix 10.** Box Plots of Clusters by Variables for the Year 2016

#### **Appendix 11.** Clusters and Countries within the Clusters for the Year 2017





### **Appendix 12.** Mean and Standard Deviation Values of Variables by Clusters for the Year 2017





 $0.6$ 

 $0.7$ 



### **Appendix 13.** Determination of the Optimal Number of Clusters for the Year 2017





 $-0.3$  $-0.2$   $-0.1$  $0.0$   $0.1 \qquad 0.2 \qquad 0.3$ silhouette coefficient values

 $0.4$  $0.5$ 





**Appendix 15.** Box Plots of Clusters by Variables for the Year 2017

**Appendix 16.** Clusters and Countries within the Clusters for the Year 2018





# **Appendix 17.** Mean and Standard Deviation Values of Variables by Clusters for the Year 2018







**Appendix 18.** Determination of the Optimal Number of Clusters for the Year 2018

**Appendix 19.** Representation of Countries by Clusters on the World Map for the Year 2018





**Appendix 20.** Box Plots of Clusters by Variables for the Year 2018

**Appendix 21.** Clusters and Countries within the Clusters for the Year 2019





# **Appendix 22.** Mean and Standard Deviation Values of Variables by Clusters for the Year 2019







### **Appendix 23.** Determination of the Optimal Number of Clusters for the Year 2019





**Appendix 24.** Representation of Countries by Clusters on the World Map for the Year 2019





**Appendix 25.** Box Plots of Clusters by Variables for the Year 2019