

Response to Reviewer 1

Dear Reviewer,

On behalf of all the authors, I would like to express our sincerest thanks for your kind review. We believe your comments are very positive and valuable. All the changes for your comments in our manuscript have been highlighted by red text (manuscript marked-copy). Here below we address the questions and suggestions.

No.	Comment	Response
1	I believe the introduction would benefit if some epidemiological data were included that show the reality of the three health problems selected for the work in your country. Perhaps it is not so necessary to show the peculiarities of the Chinese health system.	Thanks for your kind suggestions. It seems we were too focused on the quality of care and somehow missed the diseases we selected. A brief epidemiological introduction has been added in the introduction part, as following: (Page 2, line 76-90) <i>Stroke is the second leading cause of death in the world and the leading cause of death in China[17]. As estimated by Ma et al., 28.8 million strokes occurred in China at 2019, which caused 2.19 million deaths and 45.9 million disability-adjusted life-years (DALYs)[18]. The prevalence of stroke in China was 2022 per 100,000 population at 2019, higher than Europe</i>

	<i>(1870 per 100,000 population at 2017)[18, 19]. Pneumonia is a leading infectious cause of hospitalization and death among adults[20]. According to Hu et al., the hospitalization rate for pneumonia was 8.4 admissions per 1000 person-years between 2009 and 2017 and increased year by year[21]. Despite the length of hospital stay slightly decreased during the same time span, the hospitalization burden of pneumonia in Chinese adults was increasing[21]. A population-based study of about 50 million individuals shows the overall prevalence of heart failure was 1.18% in China at 2017[22]. Compared with developed countries (2.2% in the U.S. and Sweden, 4% in Germany, 1.6% in UK)[23, 24], prevalence rate of heart failure in China stays at relatively low level. The inpatient and outpatient mean cost per-capita was \$4406.8 and \$892.3, which placed a considerable burden on health systems in China[22].</i> Many thanks for pointing out that we spoke too much about China's healthcare system. Actually, we never noticed this before. Maybe it is just a matter of style, but we always want to introduce China's healthcare system as detailly as we can. China has a very hospital-centered system, which we believe is different from western society. We will take in your kind suggestion and stress less on peculiarities of the Chinese health system in this and further studies. We removed several unnecessary statements in this study, as following: (Page 2, line 48-51)
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		<i>Since 2010, public hospitals in China provide over 60% of the country's inpatient services and more than 30 % of outpatient services, and the numbers are rising year by year[6]. The success of Chinese health system reform therefore depends on whether the public hospital can be reformed to improve the quality and efficiency of health care they provide, especially the county hospitals[7]. In 2012, the State Council of China had de-termined the reform on county hospitals as the breakthrough point of whole health care system reform[8]. Standing at the top of three-tiered service delivery system (county hospital, township hospital, village clinic) in rural areas of China, the county hospitals are designed to provide essential medical services that meet the health need from more than 900 million people, approximately 70% of Chinese population[9, 10].</i>
2	Table 2. Is it necessary to indicate that there is no case of stroke in people under 18 years of age? If we know that the incidence of stroke is almost non-existent in this group of diseases,	Sorry for the confusion! Actually, we utilized a universal category for all 3 disease participants. The reason is that we would like to explore the possible quality variation between pediatric department and other department. Theoretically speaking, the pediatricians were responsible for patients aged under 19. By listing all patients under 19, we could compare the QoC between them and the rest of patients. We also wanted to explore factors associated with health outcomes, and

	what does this information provide in the table?	the factors included adult or child, gender, payment, etc. While this is not within the scope of this paper, and we are still working on it. Besides, the disease selected was not common among children, and now we are facing great challenge. All in all, we did not want to express anything by indicating that there is no case of stroke in people under 18 years.
3	Line 184. Revived aspirine could be “received aspirine”?	Sorry for the typo. Yes, we wanted to say “received aspirine”. I have refined it.
4	In the discussion section, there are some paragraphs without any bibliographic reference or that seem to be mere reflections of the authors. I can understand that it is a little unvetted subject, and there is little information about it, but they should justify their claims somehow.	We have added more reference to support our points, as following: ● <i>Just as many other counties, during past decade, the Chinese government and society put access as the national health priority[26].</i> ● <i>As consequence, the monitoring indicators and evaluation criteria of health care system surround structures, like inputs of medicines and equipments, but not capture many of the processes and outcomes that matter most to people, like correct diagnosis, timely treatment and user experience[4].</i> ● <i>Motivated by access-oriented evaluation criteria, China expands the size of doctors, nurses, hospital beds, even medical institutes rapidly during last 10 years[11, 27].</i> ● <i>Besides, due to deficient payment method and financing system, the hospital in the economically developed counties usually get more incomes than the hospital in eco-</i>

		<i>nomically underdeveloped counties[7], which could cause great quality difference as we found in this study.</i> We also add “we think” or “we believe” to stress the claims made by us, as following: ● <i>Nevertheless, it is encouraging that the quality improvement plan (QIP) unnecessarily requires extensive investment, because since we think the poor QoC should not attribute to the lack of medications or medical equipment.</i> ● <i>Firstly, we recommend to enhance training for medical workers in county hospitals, especially the in-service training.</i>
5	This is more of a question for the authors. Given what the heart failure management guidelines indicate about the use of beta-blockers, especially in people with rEF HF, do you know why has the use of this drug in its treatment not been considered a quality standard?	A great question! According to the official guideline on HF in China, the ACEI and ARB are recommended for all the HF patients. While there are some requirements on the beta-blocker, as following: Recommended: - asymptomatic heart failure - NYHA II~III - NYHA IVa (monitored strictly by physician)

		Forbidden: II AVB or above active asthma reactive airway disease Consider all these restrictions, we did not utilized beta-blockers as quality indicator.
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Once Again, thanks for your kind comments on our work. I believe these suggestions make our study much better. If you still have any more comments, please let us know.

Best regards,

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