



# THE RELATIONSHIP BETWEEN MANAGEMENT SUPPORT AND BURNOUT LEVELS AMONG HEALTH CARE WORKERS IN A LEVEL 1 GOVERNMENT HOSPITAL

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## Abstract

Burnout among healthcare workers threatens both workforce sustainability and patient safety, and is especially acute in resource-constrained public hospitals. Management support is a well-established organizational buffer against burnout, yet Philippine evidence remains concentrated in urban and private-hospital settings, leaving provincial, government-run facilities under-examined. This study examined the relationship between management support (administrative, emotional, and resource dimensions) and burnout (emotional exhaustion, depersonalization, and reduced personal accomplishment) among healthcare workers at a Level 1 government hospital in Quirino, Philippines. Using a descriptive-correlational design, a researcher-developed, content-validated 30-item questionnaire (management support subscale  $\alpha = .91$ ; burnout subscale  $\alpha = .94$ ) was administered to 130 purposively sampled full-time, direct-care staff. Data were analyzed using means and standard deviations, Pearson product-moment correlation, independent-samples t-test/one-way ANOVA, and simple linear regression, with significance set at  $\alpha = .05$ . Both overall management support ( $M = 3.04$ ,  $SD = 0.54$ ) and overall burnout ( $M = 3.14$ ,  $SD = 0.63$ ) were rated Moderate. Resource support was the weakest management-support dimension ( $M = 2.73$ ), while emotional exhaustion was the only burnout dimension reaching the High band ( $M = 3.47$ ). Management support was significantly, moderately, and negatively correlated with burnout,  $r(128) = -.57$ ,  $p < .001$ , and significantly predicted burnout, explaining 32.5% of its variance,  $F(1, 128) = 61.56$ ,  $p < .001$ . No significant differences in management support or burnout emerged across gender, age group, position, or years of service (all  $p > .05$ ). Management support, particularly resource adequacy, is a statistically significant and practically meaningful, modifiable determinant of burnout in a resource-limited government hospital. A four-component Management Support Enhancement and Burnout Reduction Program targeting resource support and emotional exhaustion is proposed for institutional adoption.

**Keywords:** *burnout; healthcare workers; job satisfaction; management support; public hospitals*



## INTRODUCTION

Healthcare workers are central to the delivery of quality, efficient, and humane patient care, yet the demanding nature of the profession routinely places them in conditions that erode physical and mental health. Burnout — a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment — has become a defining occupational hazard in healthcare, contributing to reduced productivity, higher absenteeism, and compromised patient safety (Maunder et al., 2021). The emotional and physical demands intrinsic to clinical work make healthcare professionals more vulnerable to burnout than many other occupational groups (Ghahramani et al., 2021).

Management support — encompassing administrative assistance, emotional support, and the provision of adequate resources — has been consistently identified as a key organizational buffer against burnout. Employees who perceive strong management support are less likely to develop burnout because that support fosters a sense of value, belonging, and organizational commitment (Omar et al., 2024). Conversely, systemic pressures such as inadequate funding, high patient volumes, and staff shortages intensify workplace stress, and healthcare personnel in resource-limited settings tend to experience burnout more often as a result of these system-level pressures and workload demands (Jang et al., 2021; Elhadi et al., 2023).

Although burnout and management support have each been widely studied, a gap remains in research examining their interaction in provincial healthcare establishments, where contextual factors — smaller budgets, thinner staffing complements, and more limited access to specialists and supplies — may shape outcomes differently than in urban, tertiary, or private-sector settings. Philippine evidence on healthcare-worker burnout has documented understaffing, excessive workloads, and poor remuneration as key drivers of emotional exhaustion and reduced professional engagement, with downstream effects on retention and, ultimately, on patient-safety practices (Alibudbud, 2023; International Journal of Advanced and Applied Sciences, 2023). Yet this literature is concentrated in urban centers and private or tertiary hospitals; provincial, government-run Level 1 facilities — which serve communities with the fewest alternative care options — remain comparatively under-studied (Co, 2025).

This study addresses that gap by examining the relationship between management support and burnout among direct-care healthcare workers at a Level 1 government hospital in Quirino, Philippines.

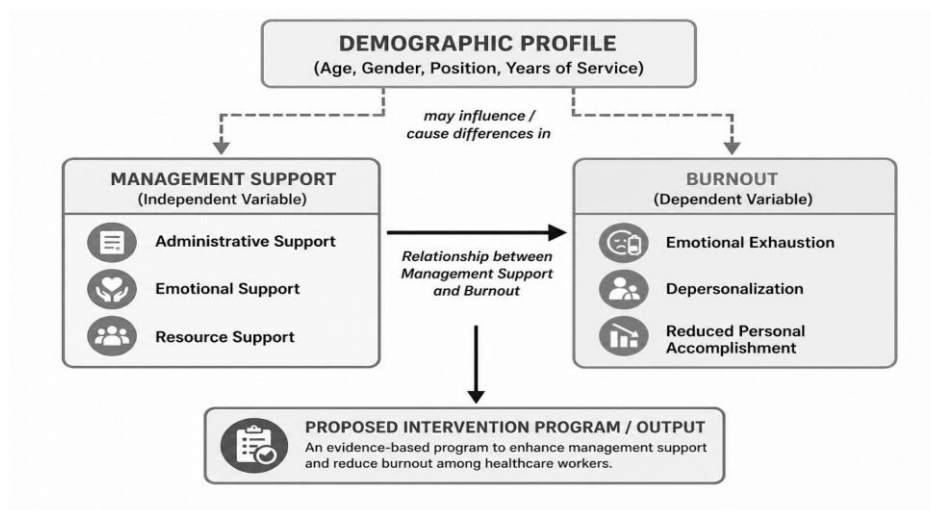
## Theoretical Framework

Three complementary frameworks anchor this study. Under the Job Demands–Resources (JD-R) model, every occupation carries both job demands (workload, time pressure, emotional strain) and job resources (management support, autonomy, adequate supplies) that respectively deplete and replenish employee well-being; when resources are insufficient to offset demands, burnout results (Bakker & Demerouti, 2017; Bakker et al., 2023). Maslach Burnout Theory conceives burnout as a three-dimensional syndrome — emotional exhaustion, depersonalization, and reduced personal accomplishment — that these frameworks jointly help explain (Maslach & Leiter, 2016). Finally, Perceived Organizational Support (POS) theory holds that when employees perceive the organization as valuing their contributions and caring about their welfare, they reciprocate with lower strain, higher engagement, and greater commitment; low perceived support, conversely, is associated with emotional exhaustion, devaluation, and turnover intention (Eisenberger et al., 1986; Eisenberger et al., 2020; Kurtessis et al., 2017).

As shown in Figure 1, management support (administrative, emotional, and resource dimensions) is conceptualized as the independent variable and burnout (emotional exhaustion, depersonalization, and reduced personal accomplishment) as the dependent variable, with demographic profile (age, gender, position, years of

service) examined as a possible source of group differences. The framework proposes that higher management support is associated with lower burnout, and that study findings can inform a targeted intervention program.

**Figure 1. Conceptual framework linking management support, burnout, demographic profile, and the proposed intervention program**



## Purpose and Hypothesis

This study aimed to (a) describe the demographic profile of respondents; (b) determine the perceived level of management support in terms of administrative, emotional, and resource support; (c) assess the level of burnout in terms of emotional exhaustion, depersonalization, and reduced personal accomplishment; (d) determine whether management support and burnout are significantly related, overall and at the dimension level; (e) determine whether management support and burnout differ significantly by demographic profile; (f) determine whether management support significantly predicts burnout; and (g) propose an evidence-based program responsive to the findings. The corresponding null hypothesis was: there is no significant relationship between management support and burnout levels among healthcare workers at the study hospital.



## METHODS

### Research Design

This study used a descriptive-correlational design. The descriptive component characterized the demographic profile and the levels of management support and burnout using frequency, percentage, and weighted mean; the correlational component tested the strength and direction of the relationship between management support and burnout using Pearson's  $r$ . This non-experimental design was appropriate because the study examined naturally occurring workplace conditions without manipulation, and because the aim was to test association and predictive strength rather than causation.

### Research Locale

The study was conducted at a 150-bed capacity, LGU-run Level 1 government hospital in Cabarroguis, Quirino, Philippines, which provides medical services to the surrounding province and communities. The setting was selected because its employees routinely face high workloads, limited resources, and a stressful work environment, making it well suited to examining burnout and management support.

### Participants and Sampling

Participants were selected through purposive sampling from among healthcare workers engaged in direct patient care at the study hospital (estimated eligible pool of 120–150 staff). A total of 130 complete and valid questionnaires were retrieved, yielding a 100% usable response rate. Inclusion criteria required that participants (a) provide direct, hands-on patient care; (b) hold full-time or permanent positions and provide informed consent; (c) be physically and mentally able to complete the survey and not be on extended leave (maternity, sick, or study leave) during data collection; and (d) be able to understand the questionnaire in English or Filipino.

### Instrument

Data were collected using a researcher-developed, structured questionnaire in three parts: (I) demographic profile (age, gender, position, years of service); (II) management support, measured across administrative, emotional, and resource support subscales; and (III) burnout, measured across emotional exhaustion, depersonalization, and reduced personal accomplishment subscales (reverse-keyed so that higher scores indicate more burnout). All items used a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree), treated as interval data for parametric analysis. Item means were interpreted using equal-interval bands: 1.00–1.79 Very Low, 1.80–2.59 Low, 2.60–3.39 Moderate, 3.40–4.19 High, and 4.20–5.00 Very High.

The instrument was developed from a review of related literature and existing measures, adapted to the study context, reviewed by content-area experts for clarity and appropriateness, and refined through pilot testing prior to distribution.

### Validity and Reliability

Content validity was established through expert review by validators with backgrounds in healthcare administration, research methodology, and psychology, followed by pilot testing with healthcare workers who were not part of the actual sample. Internal consistency was assessed using Cronbach's alpha. Subscale reliabilities were .80 (administrative support), .82 (emotional support), .75 (resource support), .88 (emotional exhaustion), .84 (depersonalization), and .82 (reduced personal accomplishment); the composite 15-item management-support scale reached  $\alpha = .91$ , and the composite 15-item burnout scale reached  $\alpha = .94$  — all exceeding the .70 threshold for acceptable reliability.



## Data Collection Procedure

Data collection proceeded in six phases: (1) securing formal institutional approval; (2) coordinating logistics with hospital administrators; (3) obtaining informed consent after orienting respondents to the study's purpose and their rights, including voluntary participation and withdrawal without penalty; (4) distributing and retrieving questionnaires face-to-face or through designated coordinators; (5) verifying, coding, and tabulating the data; and (6) statistical analysis.

## Data Analysis

Demographic data were summarized using frequency and percentage distribution. Levels of management support and burnout were summarized using weighted means and standard deviations. The relationship between overall management support and overall burnout, and between their respective dimensions, was tested using the Pearson product-moment correlation coefficient. Group differences in management support and burnout by gender were tested using an independent-samples t-test, and by age group, position, and years of service using one-way ANOVA. Simple linear regression was used to determine whether management support significantly predicted burnout. Significance was evaluated at  $\alpha = .05$  throughout.

## Ethical Considerations

The study adhered to standard ethical principles for research involving human participants: informed consent, voluntary participation, and the right to withdraw at any time without penalty; anonymity and confidentiality, with no individual identifiers collected and data used solely for academic purposes; and transparency regarding the study's objectives and procedures. Risks were minimal and limited to reflecting on work-related experiences.



## RESULTS

Data were gathered from 130 healthcare workers at the study hospital. All 130 retrieved questionnaires were complete and valid (100% usable response rate). Results are presented in the order of the study's objectives: demographic profile, levels of management support and burnout, their relationship overall and by dimension, demographic group differences, and the predictive value of management support.

### Demographic Profile

As summarized in Table 1, respondents were predominantly aged 31–40 years (45.4%) and 21–30 years (37.7%); mean age was 33.8 years. Most respondents were female (76.9%) and worked as staff nurses (56.9%), followed by nursing assistants (21.5%), medical technologists (12.3%), and midwives (9.2%). The largest tenure group had 11–15 years of service (40.8%). This profile — an experienced, female-dominated, direct-care workforce — mirrors the broader Philippine nursing workforce and situates the burnout findings that follow as most directly generalizable to bedside nursing staff.

**Table 1. Frequency and Percentage Distribution of Respondents by Demographic Profile (N = 130)**

| Profile Variable        | Category             | f   | %    |
|-------------------------|----------------------|-----|------|
| <b>Age</b>              | 21–30 years          | 49  | 37.7 |
|                         | 31–40 years          | 59  | 45.4 |
|                         | 41–50 years          | 17  | 13.1 |
|                         | 51 years and above   | 5   | 3.8  |
| <b>Gender</b>           | Male                 | 30  | 23.1 |
|                         | Female               | 100 | 76.9 |
| <b>Position</b>         | Staff Nurse          | 74  | 56.9 |
|                         | Nursing Assistant    | 28  | 21.5 |
|                         | Midwife              | 12  | 9.2  |
|                         | Medical Technologist | 16  | 12.3 |
| <b>Years of Service</b> | 5 years and below    | 28  | 21.5 |
|                         | 6–10 years           | 36  | 27.7 |

|              |                    |            |              |
|--------------|--------------------|------------|--------------|
|              | 11–15 years        | 53         | 40.8         |
|              | 16 years and above | 13         | 10.0         |
| <b>Total</b> |                    | <b>130</b> | <b>100.0</b> |

*Note. Frequencies and percentages computed from the 130 valid questionnaires.*

### Level of Management Support

Overall perceived management support was Moderate ( $M = 3.04$ ,  $SD = 0.54$ ; Table 2). Administrative support was rated highest ( $M = 3.21$ , Moderate), closely followed by emotional support ( $M = 3.16$ , Moderate), while resource support was the lowest ( $M = 2.73$ , Moderate) — only 0.13 points above the boundary of the Low band. The comparatively small standard deviations (0.54–0.65) indicate that respondents were fairly consistent in rating their support experience as middling rather than strongly positive or negative. The weak standing of resource support reflects the understaffing, limited supplies, and competing patient loads described in Section 1, and, read through the JD-R model, signals a demand–resource imbalance at the structural level (Bakker & Demerouti, 2017; Bakker et al., 2023).

**Table 2. Weighted Mean and Standard Deviation of the Level of Management Support**

| Dimension                         | M           | SD          | Interpretation  |
|-----------------------------------|-------------|-------------|-----------------|
| Administrative Support            | 3.21        | 0.65        | Moderate        |
| Emotional Support                 | 3.16        | 0.61        | Moderate        |
| Resource Support                  | 2.73        | 0.56        | Moderate        |
| <b>Overall Management Support</b> | <b>3.04</b> | <b>0.54</b> | <b>Moderate</b> |

*Note. Interpretation bands: 1.00–1.79 Very Low, 1.80–2.59 Low, 2.60–3.39 Moderate, 3.40–4.19 High, 4.20–5.00 Very High.*

### Level of Burnout

Respondents reported a Moderate overall level of burnout ( $M = 3.14$ ,  $SD = 0.63$ ; Table 3). Emotional exhaustion was the only dimension to reach the High band ( $M = 3.47$ ,  $SD = 0.80$ ) and showed the greatest dispersion, indicating that fatigue and depletion were both the most pronounced and the most variable experience among respondents. Reduced personal accomplishment followed ( $M = 3.05$ , Moderate), and depersonalization was least pronounced ( $M = 2.91$ , Moderate). This pattern is consistent with Maslach's formulation of emotional exhaustion as the core, first-appearing component of burnout (Maslach & Leiter, 2016) and with meta-analytic evidence that it is typically the most strongly experienced dimension among nurses (Galanis et al., 2021). That depersonalization remained comparatively low suggests respondents were depleted yet largely retained engagement with and compassion for patients.

**Table 3. Weighted Mean and Standard Deviation of the Level of Burnout**

| Dimension                       | M           | SD          | Interpretation  |
|---------------------------------|-------------|-------------|-----------------|
| Emotional Exhaustion            | 3.47        | 0.80        | High            |
| Depersonalization               | 2.91        | 0.65        | Moderate        |
| Reduced Personal Accomplishment | 3.05        | 0.62        | Moderate        |
| <b>Overall Burnout</b>          | <b>3.14</b> | <b>0.63</b> | <b>Moderate</b> |

Note. Reduced-personal-accomplishment items were reverse-keyed so that higher scores indicate more burnout.

### Relationship Between Management Support and Burnout

A Pearson product-moment correlation was computed to test the study's central hypothesis. As shown in Table 4, overall management support and overall burnout were significantly, negatively, and moderately correlated,  $r(128) = -.57$ ,  $p < .001$ ; the null hypothesis was rejected. As perceived management support increases, burnout decreases. By conventional benchmarks (below .20 negligible, .20–.39 weak, .40–.59 moderate, .60–.79 strong, .80 and above very strong), the magnitude of  $-.57$  represents a moderate relationship approaching the strong range. This result is consistent with the JD-R buffering hypothesis, in which job resources such as management support attenuate the strain produced by job demands (Bakker et al., 2023), and with POS theory, in which employees who feel valued reciprocate with lower strain (Eisenberger et al., 2020; Kurtessis et al., 2017), and aligns with recent nurse-focused studies reporting inverse relationships between organizational or management support and burnout (Zhang et al., 2024; Ren et al., 2023; Abdulmohdi, 2024).

**Table 4. Test of Relationship Between Overall Management Support and Overall Burnout**

| Variables                    | n   | Pearson r | p      | Decision on H0 |
|------------------------------|-----|-----------|--------|----------------|
| Management Support & Burnout | 130 | –0.57     | < .001 | Reject H0      |

Note.  $t(128) = -7.85$ . Significant, moderate, negative relationship.

### Dimension-Level Relationships

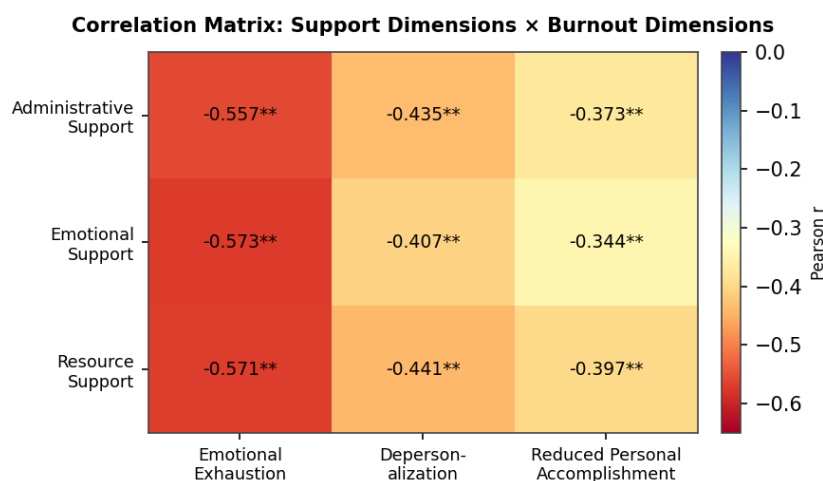
A correlation matrix (Table 5) examined the association between each management-support dimension and each burnout dimension. All nine pairs were significantly and negatively correlated ( $p < .01$ ). Emotional exhaustion was the burnout facet most strongly tied to every form of support ( $r = -.557$  to  $-.573$ ), while reduced personal accomplishment showed the weakest associations ( $r = -.344$  to  $-.397$ ). The single strongest relationship in the matrix was between emotional support and emotional exhaustion ( $r = -.573$ ), consistent with evidence that supervisory and emotional support are particularly protective against the affective depletion at the core of burnout (Pohl et al., 2023; Petersen et al., 2023). Resource support also correlated strongly with emotional exhaustion ( $r = -.571$ ), consistent with a setting where inadequate staffing and supplies drive fatigue (Muir et al., 2025).

## Correlation Matrix of the Dimensions of Management Support and Burnout

| Management Support Dimension | Emotional Exhaustion | Depersonalization | Reduced Personal Accomplishment |
|------------------------------|----------------------|-------------------|---------------------------------|
| Administrative Support       | -0.557**             | -0.435**          | -0.373**                        |
| Emotional Support            | -0.573**             | -0.407**          | -0.344**                        |
| Resource Support             | -0.571**             | -0.441**          | -0.397**                        |

Note. \*\* $p < .01$ , two-tailed,  $n = 130$  for all nine coefficients.

**Figure 2. Heatmap of the correlation matrix (support dimensions × burnout dimensions); darker shading indicates a stronger negative Pearson  $r$**



## Demographic Group Differences

An independent-samples  $t$ -test (gender) and one-way ANOVA (age group, position, years of service) tested whether management support and burnout differed by demographic profile (Table 6). None of the eight comparisons was statistically significant (all  $p > .05$ ). Management support was perceived similarly across all demographic groups, and burnout did not differ by gender, age group, position, or years of service, indicating that burnout in this hospital is shaped less by who the worker is than by the shared conditions under which everyone works — consistent with local evidence that burnout is driven primarily by organizational conditions rather than individual characteristics (Co, 2025).

**Table 6. Test of Differences in Management Support and Burnout by Demographic Profile**

| Grouping Variable | Variable Tested    | Test   | Statistic  | p    | Decision |
|-------------------|--------------------|--------|------------|------|----------|
| Gender            | Management Support | t-test | $t = 0.36$ | .718 | ns       |



|                  |                    |        |             |      |    |
|------------------|--------------------|--------|-------------|------|----|
| Gender           | Burnout            | t-test | $t = -0.09$ | .932 | ns |
| Age Group        | Management Support | ANOVA  | $F = 1.019$ | .387 | ns |
| Age Group        | Burnout            | ANOVA  | $F = 1.799$ | .151 | ns |
| Position         | Management Support | ANOVA  | $F = 1.161$ | .327 | ns |
| Position         | Burnout            | ANOVA  | $F = 0.891$ | .448 | ns |
| Years of Service | Management Support | ANOVA  | $F = 0.394$ | .758 | ns |
| Years of Service | Burnout            | ANOVA  | $F = 0.462$ | .710 | ns |

*Note.*  $df = 128$  for the *t*-test; one-way ANOVA for the three-or-more-category variables. *ns* = not significant at .05.

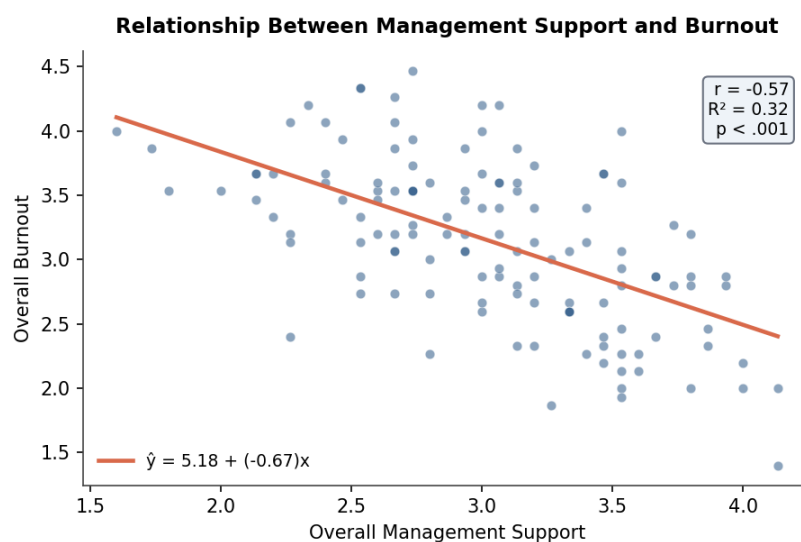
### Management Support as a Predictor of Burnout

Simple linear regression tested whether overall management support significantly predicted overall burnout (Table 7). Management support significantly predicted burnout,  $F(1, 128) = 61.56$ ,  $p < .001$ ,  $R^2 = .325$ , explaining approximately 32.5% of the variance in burnout. The unstandardized regression equation was  $\text{Burnout} = 5.18 + (-0.67 \times \text{Management Support})$ : each one-point increase in perceived management support was associated with a 0.67-point decrease in burnout on the five-point scale. For example, raising a unit's average support score from the observed 3.04 to 3.50 would, on this model, lower predicted burnout from 3.14 to approximately 2.83. That a single predictor accounts for roughly a third of the variance in burnout is a substantial result for cross-sectional field data in a complex human-services setting, and elevates management support from a correlate to a defensible predictive determinant of burnout (Zhang et al., 2024; Palvimo et al., 2023).

**Table 7. Regression Analysis of Management Support Predicting Burnout**

| Predictor          | B     | Constant | R    | R <sup>2</sup> | F     | p      |
|--------------------|-------|----------|------|----------------|-------|--------|
| Management Support | -0.67 | 5.18     | 0.57 | 0.325          | 61.56 | < .001 |

*Note.*  $F(1, 128) = 61.56$ . Criterion: overall burnout. Predictor: overall management support.

**Figure 3. Scatterplot of management support and burnout with fitted least-squares regression line (n = 130)**



## DISCUSSION

This study examined the relationship between management support and burnout among direct-care healthcare workers at a Level 1 government hospital. The central finding — a significant, moderate, negative relationship between management support and burnout,  $r = -.57$ ,  $p < .001$ , with management support explaining approximately 32.5% of the variance in burnout — can be interpreted coherently through the study's three guiding frameworks.

### Interpretation in Light of Theory and Prior Literature

Under the JD-R model, burnout arises when job demands chronically outweigh job resources; management support constitutes a critical bundle of resources that healthcare workers draw on to meet the demands of direct patient care, and the observed inverse relationship supports the JD-R buffering hypothesis (Bakker & Demerouti, 2017; Bakker et al., 2023). The dimension-level pattern is telling: resource support was the weakest support dimension ( $M = 2.73$ ), while emotional exhaustion was the most pronounced burnout facet ( $M = 3.47$ ) — precisely the demand–resource imbalance the JD-R model predicts in a lean-staffed, resource-constrained government hospital.

Under POS theory, healthcare workers who perceive that management values their contributions reciprocate with greater engagement and lower strain (Eisenberger et al., 1986; Eisenberger et al., 2020; Kurtessis et al., 2017). Because respondents in this study perceived only moderate overall support ( $M = 3.04$ ), the reciprocal protective effect was correspondingly partial, leaving burnout at a moderate overall level ( $M = 3.14$ ) — a pattern consistent with recent nurse-focused evidence linking higher perceived organizational support to lower burnout (Zhang et al., 2024; Ren et al., 2023; Abdulmohdi, 2024).

Under Maslach Burnout Theory, emotional exhaustion is the dominant, first-appearing component of the burnout syndrome (Maslach & Leiter, 2016), and this study's finding that emotional exhaustion was both the most pronounced dimension and the dimension most strongly (and uniformly) correlated with every form of support — most strongly with emotional support,  $r = -.573$  — echoes evidence that specific forms of support map onto specific facets of burnout (Pohl et al., 2023; Petersen et al., 2023) and lends construct validity to the three-dimensional model used here.

### Practical and Policy Implications

Because management support is both associated with and predictive of burnout, hospital leaders can meaningfully reduce burnout by strengthening administrative, emotional, and resource support. The predictive finding ( $R^2 = .325$ ) indicates that a measurable share of burnout is attributable to a modifiable organizational factor rather than to fixed individual traits: improving the adequacy of staffing and supplies, instituting consistent supervisory and peer support, and distributing workload fairly can each be expected to reduce burnout. This supports institutional and government policies that expand nurse staffing, fund adequate resources, and embed managerial-support practices, consistent with calls to address the structural drivers of nurse burnout in the Philippines (Alibudbud, 2023; Tiu et al., 2025). Because burnout in this sample was shaped by shared organizational conditions rather than by gender, age group, or position (Section 3.6), policy responses are most appropriately directed at institution-level and system-level levers — such as additional staffing positions and sustained resource funding — rather than at individual workers alone.

### Proposed Intervention Program

Consistent with these findings, a four-component Management Support Enhancement and Burnout Reduction Program (MSE-BRP) is proposed, prioritizing (1) resource support — the weakest management-support dimension — through needs assessment, staffing advocacy, and a supply-monitoring system; (2) emotional



support — targeting emotional exhaustion, the most pronounced burnout facet — through mentorship, structured debriefing, and access to counseling; (3) administrative support, through transparent duty-rostering, staff recognition, and regular feedback; and (4) institutionalized burnout monitoring, through routine screening and wellness programming, with particular attention to less-tenured staff. This program logic is consistent with intervention evidence indicating that combined organizational and individual-directed approaches — including mindfulness-based and cognitive-behavioral techniques — reduce nurse burnout (Yildirim et al., 2023; Sharin et al., 2025; Hsu et al., 2024).

## Limitations

Several limitations temper these findings. First, the cross-sectional, correlational design establishes association and prediction but not causation; although management support statistically predicted burnout, the design cannot rule out reverse or reciprocal influences. Second, the researcher-made instrument, while validated and reliable in this sample ( $\alpha = .75-.94$  across subscales), may not capture every nuance of the constructs as fully as established multi-item inventories. Third, purposive sampling of 130 respondents within a single Level 1 hospital limits generalizability to other facilities and regions. Fourth, self-reported perceptions of support and burnout may be shaped by transient workplace conditions at the time of data collection, such as recent staffing fluctuations or seasonal patient loads.

## Conclusion

Healthcare workers at this Level 1 government hospital perceived management support and experienced burnout at moderate levels overall, indicating that organizational support, while present, remains insufficient to fully offset the demands of direct patient care. Resource support was the weakest aspect of management support, and emotional exhaustion was the most prominent burnout facet, marking clear priorities for institutional attention. Management support was significantly, moderately, and negatively related to burnout and significantly predicted it, confirming that stronger management support is associated with lower burnout and rejecting the null hypothesis. These findings support institution-wide strategies — anchored in the proposed MSE-BRP — that strengthen resource adequacy and emotional support as actionable levers for reducing burnout and protecting the quality and safety of patient care in resource-limited public hospitals.

## Recommendations for Future Research

Future studies should replicate this design in Level 2 or Level 3 government hospitals using larger, probability-based samples to improve generalizability; incorporate qualitative or mixed-methods approaches to capture the lived experience of management support and burnout in greater depth; and evaluate the effectiveness of organization-directed interventions, which remain understudied relative to individual-directed approaches (Yildirim et al., 2023).



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