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Lifestyle Of Government Physicians: Towards Good Health and Well Being

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Abstract: This study explores the lifestyle behaviors of 104 government physicians (Provincial, City, and Municipal Health Officers) in Central Luzon, Philippines, against the backdrop of rising non-communicable diseases (NCDs) and the mandates of Sustainable Development Goal #3. This study employed a quantitative descriptive-correlational design. Using the Lifestyle Medicine Assessment tool, the research evaluates five key health pillars: Nutrition, Movement, Substance Use, Connectedness, and Recovery. The results reveal a significant "Healer's Paradox". While these medical leaders excel at avoiding active harm—scoring high in the Substance Use and Connectedness domains—they struggle significantly with foundational physiological needs. Movement and Recovery (sleep and stress management) were identified as the primary "danger zones," with average scores falling below the 5.0 threshold on a 10-point scale. Demographic & socioeconomic influence the gender gap. The workforce is predominantly female (67%), and notably, only female physicians reached the "Excellent" lifestyle tier; no male participants achieved this status. Statistical analysis showed that while age, gender, and marital status had no significant correlation with overall lifestyle, Education ($p=0.010$) and Salary Grade ($p=0.000$) were definitive predictors of health habits. This suggests that financial stability provides the necessary "scaffolding" for healthy choices, though high-ranking roles simultaneously impose time-based barriers to rest. The primary obstacles reported were a "Lack of Time" (76.9%) and "Exhaustion" (60.6%), rather than a lack of medical knowledge. The study concludes that a physician's lifestyle is less a matter of personal willpower and more a byproduct of their Workplace Socioeconomic Environment. Because these health officers act as "Allocators of Scarcity" in local government, their personal wellness directly impacts their tendency to advocate for preventive public health budgets. To bridge the "knowledge-practice gap," the study proposes an action plan focused on institutional reforms rather than further education. Key recommendations include: "Institutionalized Recovery" such as mandating "off-grid" hours to protect sleep and reduce burnout. "Environmental Restructuring" which involves reforming government canteen procurement to improve food accessibility and implementing "walking meetings" to combat sedentary desk-bound work. And "Public Administration Reform" which includes recognizing that a resilient health system requires the physical and mental well-being of its leaders to ensure sustainable community health outcomes.

Index Terms – Lifestyle Medicine, Non-Communicable Diseases, Healthy Lifestyle, Sustainable Development Goal, Health and Well Being

I. INTRODUCTION

1.1 Background of the Study

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, rather than merely the absence of disease. Achieving this state requires a delicate balance of emotional and environmental factors, transforming health from a static condition into a dynamic resource for daily living. In the modern public health landscape, well-being is increasingly viewed as a reflection of a society's resilience and its capacity for sustainable action.

According to the Department of Health (DOH), health outcomes are shaped by a complex interplay of factors, with socioeconomic elements (40%) and health behaviors (30%) playing the most significant roles. Physical environment and healthcare access contribute the remaining 30%. These behaviors, when practiced consistently, evolve into lifestyle habits that either nourish or compromise long-term health.

A healthy lifestyle is a critical defense against Non-Communicable Diseases (NCDs), which currently account for 74% of global deaths—equivalent to 41 million lives lost annually. In the Philippines, the burden is equally severe; ischemic heart disease, cancer, and stroke remain the leading causes of mortality as of 2025. Specifically, in Central Luzon, cardiovascular diseases continue to be the primary cause of death, claiming over 13,000 lives in 2024 alone (Philippine Statistics Authority, 2026)

To combat this crisis, the American College of Lifestyle Medicine (ACLM) advocates for an evidence-based approach centered on six pillars: Whole-food, plant-predominant eating, Physical activity, Restorative sleep Stress management, Avoidance of risky substances and Positive social connections By addressing the root causes of chronic illness, Lifestyle Medicine offers a pathway to prevent, treat, and often reverse conditions like type 2 diabetes and heart disease.

The importance of this field was tragically highlighted during the COVID-19 pandemic, where a significant percentage of medical fatalities involved physicians with pre-existing lifestyle-related comorbidities. Beyond personal survival, a physician's own health is a powerful clinical tool. Research indicates that doctors who embody healthy habits are more effective at motivating their patients to do the same. As leaders in the healthcare system, physicians serve as the "critical" bridge between health policy and patient action.

This study aligns with the United Nations' Sustainable Development Goal 3 (Good Health and Well-being), which aims to reduce premature NCD mortality by one-third by 2030. Domestically, the DOH has established the Health Promotion Framework Strategy (HPFS) 2030 through Administrative Orders 2020-042 and 2021-0063. These policies provide a 10-year roadmap for institutionalizing health promotion across province-wide and city-wide health systems.

Driven by a professional background in Lifestyle Medicine and public health administration, the researcher seeks to examine the lifestyle habits of government physicians in Central Luzon. By identifying the barriers these professionals face in maintaining their own health, this study proposes interventions to support those at the forefront of the healthcare system. Ultimately, improving the well-being of physicians creates a ripple effect, fostering a more productive, vibrant, and stable society while providing vital implications for Public Administration.

1.2 Statement of the Problem

This study aimed to examine the lifestyle of government physicians in Central Luzon.

Specifically, the study sought to determine the following:

1. How is the profile of government physicians of Central Luzon be described and analyzed in areas of
   - 1.1 Demographic
   - 1.1.1 age
   - 1.1.2 gender
   - 1.1.3 marital or civil status
   - 1.1.4 province/city of work assignment
   - 1.2 Socio-economic
   - 1.2.1 education/specialization
   - 1.2.2 job status/position
   - 1.2.3 income (salary grade)
2. How is the lifestyle of government physicians of Central Luzon be described and evaluated in terms of:
   - 2.1 Nutrition
   - 2.2 Movement
   - 2.3 Substance use

2.4 Connectedness
2.5 Recovery

3. Is there a significant relationship between the, demographic socioeconomic profile and lifestyle of government physicians of Central Luzon?
4. What are the problems encountered in promoting healthy lifestyle among government physicians of Central Luzon?
5. What measures can be proposed to address the problems encountered?
6. What are the implications of the study to Public Administration?

1.3 Scope and Delimitations

This study looked into the demographic profile, socioeconomic profile such as age, gender, marital or civil status, religion, education (specialty), job status, family and social support and income. It determined the lifestyle (health practices) of government physicians of Central Luzon such as nutrition, movement (physical activity or exercise), substance use (smoking, alcohol), social connectedness and recovery which includes sleep and stress management.

The respondents included Provincial Health Officers (PHOS), City Health Officers (CHOs) and Municipal Health Officers (MHOs) who are currently employed by the Local Government Units of Central Luzon (Angeles City, Aurora, Bataan, Bulacan, Nueva Ecija, Olongapo City, Pampanga, Tarlac, Zambales). This research focused exclusively on the correlations between demographic and socioeconomic profile, and lifestyle, without exploring other factors that may influence these variables. Only correlational analysis was used to examine the relationships between these variables. Respondents received a questionnaire via a Google Form link. Data collection took place from February 10, 2026 until March 12, 2026 only.

Demographic profile and socioeconomic profile of the respondents, as well as their lifestyle habits, were summarized using descriptive statistics like frequency and percentage. Pearson r was applied to examine the relationship between variables, identifying any significant positive or negative correlations. A 21-item questionnaire was used, The Lifestyle Assessment Tool created by Dr. Jonathan Bonnet. There were 104 respondents in the study.

II. RESEARCH METHODOLOGY

2.1 Population and Sample

The study focused on a finite population of N = 137 government physicians across Region III (Central Luzon), specifically comprising 7 Provincial Health Officers (PHO), 14 City Health Officers (CHO), and 116 Municipal Health Officers (MHO). Using Slovin's Formula with a 5% margin of error, a target sample of 103 was established. The final cohort consisted of 104 government physicians who successfully completed the survey. Participants were selected using snowball sampling (chain referral), leveraging the researcher's professional standing as a medical doctor and former president of the Tarlac Medical Society. This non-probability technique, facilitated by digital communication platforms and medical society networks, allowed for efficient access to busy medical leaders across the seven provinces of the region.

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2.2 Data and Sources of Data

The primary tool used was The Lifestyle Medicine Assessment (LMA), which was adopted from the framework developed by Dr. Jonathan Bonnet and endorsed by the American Academy of Family Physicians (AAFP).

Structure: The 21-item instrument covers six pillars: nutrition, movement, substance abuse, social connectedness, sleep, and stress management. It features 10 yes/no questions and 11 numeric responses.

Scoring: Each domain is scored up to 10 points, with a "Total Perfect Score of 50" representing the clinical gold standard for chronic disease prevention.

Validation: The study used quantitative methods to assess content and face validity, calculating item-level and scale-level validity indexes (I-CVI, S-CVI, I-FVI, S-FVI). Thresholds of I-CVI/I-FVI ≥.79 and S-CVI/S-FVI average ≥ .80 were applied. Eleven experts evaluated the 21-item LMA, yielding I-CVI ≥.91 and I-FVI ≥.81, with excellent kappa values. S-CVI averages for relevance and clarity were .99 and .95, respectively, indicating excellent content and face validity for the 21-item LMA (American Journal of Lifestyle Medicine , April 2024).

2.3 Data Collection

Data were collected digitally via Google Forms (February to March 2026) to accommodate the demanding schedules of the physicians. The link was distributed to health officers across the seven provinces of Central Luzon (Aurora, Bataan, Bulacan, Nueva Ecija, Pampanga, Tarlac, and Zambales). To ensure a high response rate, the researcher utilized clear communication and considerate follow-ups through professional group chats. Once the statistically sufficient sample of 104 was reached, the link was closed to maintain data integrity.

2.4 Data Analysis

The study employed a three-tiered statistical approach to analyze the data.

Frequency Distribution: Used to translate raw responses into a "composite sketch" of the participants, identifying dominant age brackets, gender, and economic norms.

Percentage Distribution: Applied to standardize the data across different leadership tiers (PHO, CHO, MHO) and rank the six pillars of lifestyle medicine by intensity of adherence. This served as a baseline for identifying which domains require the most urgent policy support.

Pearson's r: Utilized for inferential analysis to determine the correlation between socioeconomic factors and lifestyle scores. This procedure identified whether professional backgrounds were statistically significant predictors of health behaviors, moving the study from simple observation to actionable intervention strategies.

Lifestyle Medicine Assessment - Scoring Matrix

	Question	YES	NO	DOMAIN
1	Felt your life had a sense of purpose	2	0	Connectedness
2	Used olive oil as your primary oil or used no oil when cooking	1	0	Nutrition
3	Engaged in two or more spiritual or religious practices (e.g. meditation prayer church services etc.)	2	0	Connectedness
4	Felt that you were able to manage and deal with stressors effectively most days	2	0	Recovery
5	Interacted with one or more club(s) or organization(s) (e.g. athletic community school group etc.)	2	0	Connectedness
6	Smoked vaped or used tobacco/e-cigarettes	0	6	Substance use
7	Visited or spoke to a close friend or family member on three or more separate occasions	2	0	Connectedness
8	Woke up feeling refreshed and rested on most days	2	0	Recovery
9	Spent at least two hours in nature (approximately 20 minutes daily)	2	0	Connectedness
10	Felt you had enough time to take care of yourself most days	1	0	Recovery

		<1	1	2	3	4	5	6	7	8	9	10+	DOMAIN
11	Total number of sit-down or take-out restaurant meals	1	1	1	1	0	0	0	0	0	0	0	Nutrition
12	Total number of resistance training workouts performed (e.g. pushups squats pullups etc.)	0	1	2	2	2	2	2	2	2	2	2	Movement
13	Total number of sweetened drinks consumed (e.g. juice sweetened coffee or tea soda sports drinks)	2	2	2	0	0	0	0	0	0	0	0	Nutrition

14	Highest number of alcoholic drinks consumed on any single day	2	2	2	2	0	0	0	0	0	0	0	Substance
15	Average number of packaged snacks per day (e.g. chips crackers cookies candy protein bars etc.)	2	2	0	0	0	0	0	0	0	0	0	Nutrition
16	Average number of hours slept per night	0	0	0	0	0	0	3	5	5	5	5	Recovery
17	Average number of daily servings of fruit	0	1	2	2	2	2	2	2	2	2	2	Nutrition
18	Average number of hours spent sitting each day	3	3	3	3	3	1	1	0	0	0	0	Movement
19	Average number of alcoholic drinks consumed on days alcohol was consumed (select less than one if you did not drink any alcohol)	2	2	0	0	0	0	0	0	0	0	0	Substance
20	Average number of daily servings of vegetables	0	1	1	2	2	2	2	2	2	2	2	Nutrition

		<30	**30**	**45**	**60**	**90**	**120**	**150**	**180 +**	**DOMAIN**
21	Total amount of cardiorespiratory exercise during the week (e.g. brisk walk jog etc.) (in minutes)	0	1	1	2	3	4	5	5	Movement

Individual Domain Interpretation

Mean score	Interpretation	Remarks	**Analysis**
0-4.0	Below average	Needs Improvement	This is the lowest bracket. When a respondent falls into this category, it indicates a critical gap between their current habits and the physiological requirements for longevity. In a clinical leadership context, this is a red flag. It doesn't just mean "poor diet" or "lack of sleep"; it suggests that the demands of their administrative or clinical role have completely eclipsed their capacity for self-care. Instead of calling it "unhealthy," frame this as **"High Occupational Vulnerability."** It suggests that the system—or the individual's current approach to it—is currently unsustainable. This result serves as a critical indicator that the individual "**Needs Improvement**," suggesting that the current habits or conditions within this domain are insufficient and require targeted intervention.

4.01-6.0	Average	Fair Adherence	A respondent in this bracket is likely managing their well-being reactively rather than proactively. They are doing enough to function, but they lack the buffer required to handle periods of high stress—such as during surge capacity or administrative crises. **"Functional Sustainability"** suggests that the respondent is keeping their head above water, but they are one major professional stressor away from slipping into a higher-risk category. While this indicates a foundational level of stability, the remark of **"Fair Adherence"** implies that while the individual is meeting basic requirements, there is still significant room for growth and more consistent effort to reach a higher standard.
6.01-8.0	Very Good	Low Risk	This is the target zone for most high-level medical administrators. At this level, lifestyle medicine is likely integrated into their daily routine. They aren't necessarily perfect, but they have established "guardrails" that prevent them from neglecting their health during busy work cycles. This is described as "**Professional Resilience.**" It demonstrates that the respondent has developed a consistent, protective lifestyle that mitigates the inherent risks of working in the public health sector. This range suggests a high level of competency or health. It is characterized as **"Low Risk,"** meaning the individual has established sustainable patterns that protect them from immediate setbacks in this specific area.
8.01-10.0	Excellent	Optimal Wellness	Scores in this range represent peak performance. Physicians here have likely moved beyond viewing lifestyle medicine as a "checklist" and have made it a core element of their professional identity. This indicates that the individual isn't just surviving their role but is actively leveraging their personal health to enhance their decision-making and leadership capacity. This is the highest possible tier, representing **"Optimal Wellness."** At this level, the individual is not just meeting expectations but is thriving, demonstrating peak performance and a mastered balance within the domain.

Then the sum of the scores of each domain were interpreted as follows:

Individual Domain Scoring Interpretation	**Individual Domain Score**	**Remarks**	**Analysis**
Perfect score! Talk to your provider about other things you can do beyond this assessment to improve your health.	10	Optimal Adherence	A **"Perfect Score"** is the gold standard. In Dr. Bonnet's framework, reaching a 10 in a specific domain means the physician has fully integrated that lifestyle pillar into their life. At this level, the assessment shifts from "fixing problems" to "transcending the basics." It challenges the individual to look beyond the survey to find even more nuanced ways to enhance their longevity and leadership energy. The highest level of achievement which translates to **Negligible Risk.** This indicates Optimal Adherence, meaning the individual has fully mastered the requirements of that domain. Even at this peak level, the assessment encourages proactive health management, suggesting that the individual consult with their provider to find ways to

			maintain this momentum or explore health goals beyond the scope of this specific test.
Although you are doing well, a few tweaks to address the remaining domain items could significantly improve your health.	7-9	Satisfactory Progress	This range represents **"Fair to Strong Adherence."** Most high-functioning professionals tend to land here. The interpretation recognizes that the foundation is solid, but "tweaks" are necessary. It acknowledges that while the respondent is "doing well," they haven't yet reached a state of physiological or mental peak performance. It's the difference between being "not sick" and being "truly well." This tier represents **Satisfactory Progress**, where the individual is clearly on the right track. While the results are positive, they aren't perfect; the narrative suggests that making a few minor "tweaks" to address the remaining items could still lead to a meaningful boost in overall well-being.
Significant room for improvement. Discuss this area specifically with your provider to see how you can improve your health.	<7	Needs Intervention	When a score falls below 7, it is categorized as **High Risk**. This result suggests that there is **"significant room for improvement"** within that specific domain. In this study, this is a critical marker. It suggests that the respondent is failing to meet basic benchmarks in a specific pillar, whether that is sleep, nutrition, or stress management. This isn't just a low score; it's a clinical recommendation for professional consultation. For a medical officer, falling below 7 indicates that their lifestyle habits may be actively compromising their health rather than supporting it. At this stage, the status is labeled as **Needs Intervention**, serving as a clear signal that the individual should have a focused discussion with their healthcare provider to develop a strategy for better health.

2.4 Theoretical framework

Understanding how health is shaped requires looking beyond simple willpower and examining the deep connection between social environment and personal action. This study bridges several sociological and medical theories to explain how government physicians in Central Luzon navigate their well-being.

At its core, the research draws from the Health Lifestyle Theory and Control Theory. While the former emphasizes how social class and living conditions set the stage for our habits, the latter suggests that we constantly adjust our actions to meet personal goals. This creates a central tension in medical sociology: the "agency versus structure" debate. It asks whether a physician's health is a result of their own choices or a byproduct of their professional environment.

To answer this, the study utilizes the Lifestyle Medicine Framework, focusing on the "mismatch" between our biology and the modern workplace. By evaluating six pillars—nutrition, movement, substance use, connectedness, recovery, and stress management—the research views health as a holistic balance rather than just the absence of disease. This is further layered with the Social Determinants of Health, acknowledging that a doctor's salary grade and work assignment are just as influential as their medical knowledge.

The research follows a clear Input-Process-Output (IPO) model. The Inputs are the physicians' demographic and socioeconomic profiles, including their age, rank, and location. These factors flow into the Process, where the Lifestyle Medicine Assessment tool evaluates their daily habits and identifies systemic barriers to wellness. Finally, the Output transforms these findings into actionable policy recommendations. By aligning personal health with Public Administration goals and Sustainable Development Goal #3, the study aims to create a more resilient health workforce that can better serve the community.

Ethics in Research

To ensure the highest standard of research integrity, this study strictly followed ethical protocols by providing each participant with a comprehensive informed consent briefing that emphasized the voluntary nature of their involvement and their right to withdraw without penalty. Data collection was conducted through a secure, anonymized Google Forms interface that excluded personally identifiable information, instead utilizing numerical codes to maintain participant confidentiality. These identifiers were managed solely by the primary researcher and stored in a secure, locked location, ensuring that all electronic data remained untraceable and protected throughout the analysis and reporting **phases.**

III. RESULTS AND DISCUSSION

Table 1. Demographic and Socioeconomic Profile

DEMOGRAPHICPROFILE			
Category	**%**	**Category**	**%**
Age		**Sex**	
Young Adult (25–44)	25	Female	67
Middle Age (45–59)	52	Male	33
Elderly (60–74)	23		
Total	**100**	**Total**	**100**
Province/City		**Civil Status**	
Nueva Ecija	25	Married	70.00
Bulacan	22	Single	25.00
Tarlac	18	Separated/Annulled	3.00
Pampanga	15	Widowed	2.00
Zambales	7		
Bataan	6		
Aurora	5		
Angeles City	1		
Olongapo City	1		
Total	**100**	**Total**	**100**
SOCIOECONOMIC PROFILE			
Category	**%**	**Category**	**%**
Education (Specialization)		**Job Status/Position**	
General Practitioner	37.50	Municipal Health Officer	80
Family Medicine	22.12	City Health Officer	14
Internal Medicine	14.42	Provincial Health Officer	6
Pediatrics	12.50		
Obstetrics and Gynecology	4.81		
General Surgery	0.96		
Others	7.69		
Total	**100**	**Total**	**100**
Income Salary Grade	**%**		
SG 24	61.54		
SG 21	16.35		
SG 25	11.54		
SG 22	3.85		
SG 23	2.88		
SG 26	1.92		
Contractual	1.92		
Total	**100**		

The demographic and socioeconomic profile highlights a group of healthcare professionals—predominantly female, middle-aged, and married—serving in various capacities across Central Luzon. The majority of the respondents fall into the Middle Age (45–59) category at 52%, followed by young adults

(25%) and the elderly (23%). This suggests a workforce with significant clinical and administrative experience. Gender distribution shows a strong female presence at 67%, more than doubling the number of male respondents (33%).

A large majority (70%) are married, with single individuals making up 25%. Respondents are spread across several provinces, with the highest concentrations in Nueva Ecija (25%), Bulacan (22%), and Tarlac (18%), as these areas contain a high number of municipalities. The professional data indicates a group primarily composed of frontline public health administrators and primary care provider such as General Practitioners and Family Physicians. Overall, the profile portrays a stable, experienced, and predominantly female workforce of medical officers dedicated to municipal-level public health service.

An overwhelming 80% serve as Municipal Health Officers (MHOs). This high percentage suggests the study focuses on local government health leadership. City and Provincial Health Officers represent smaller portions of the group (14% and 6%, respectively). While 37.5% are General Practitioners, many have pursued further specialization. Family Medicine (22.12%) and Internal Medicine (14.42%) are the most common specialties, which aligns with the needs of community-based healthcare. The financial profile shows a concentrated peak at the higher end of the government pay scale. Most respondents (61.54%) are at Salary Grade 24, which is consistent with the standard pay for MHO positions in the Philippines. About 16.35% are at SG 21, while a small group of senior officials (roughly 13%) hold SG 25 or 26. Contractual workers represent a very small fraction at 1.92%.

Table 2. Overall Lifestyle Score of the 5 Domains

Domain	Individual Domain Score	Remarks	Risk Categorization	Interpretation
Nutrition	6	Needs Intervention	High Risk	Significant room for improvement. Discuss this area specifically with your provider to see how you can improve your health.
Movement	5	Needs Intervention	High Risk	Significant room for improvement. Discuss this area specifically with your provider to see how you can improve your health.
Substance use	9	Satisfactory Progress	Low risk	Although you are doing well, a few tweaks to address the remaining domain items could significantly improve your health.
Connectedness	7	Satisfactory Progress	Low risk	Although you are doing well, a few tweaks to address the remaining domain items could significantly improve your health.
Recovery	5	Needs Intervention	High Risk	Significant room for improvement. Discuss this area specifically with

				your provider to see how you can improve your health.
Total Score	**32**	**Established Adherence**	**Low Risk**	**You have many healthy habits, though there are a few areas that you should assess your habits in to see if you can improve them.**

Table 2 reveals the LMA tool scores each of the five domains from 0–10 points, for a maximum total score of 50 points. Higher scores indicate healthier lifestyle behaviors while lower scores identify specific "danger zones" where a clinician or coach can intervene. The synthesis of the Lifestyle Medicine Assessment (LMA) data reveals a compelling "Healer's Paradox" among health leaders in Central Luzon. While an aggregate score of 32 places the group within the "Very Good" and "Established Adherence" categories, this numerical average is misleading; it is artificially inflated by high marks in Substance Use and Connectedness. These social and behavioral strengths act as a "safety net" that masks critical physiological "danger zones." In reality, the core pillars of physical health—Nutrition (6), Movement (5), and Recovery (5)—consistently fall into the "High Risk" and "Needs Intervention" categories.

This bimodal health profile depicts a workforce that is "functioning but depleted," maintaining high professional performance by borrowing from physical health reserves. The alarming deficit in Recovery and Movement suggests that the systemic demands of public health governance—long hours, sedentary administrative burdens, and 24-hour accountability—are actively sabotaging the biological requirements for restorative rest and physical activity. The data implies that these leaders do not lack health literacy or willpower; rather, they are victims of a work environment that lacks the necessary infrastructure for self-care.

Ultimately, the transition from "Established Adherence" to an "Excellent" lifestyle (41–50) requires moving beyond individual habit-tracking toward a systemic environmental redesign. Addressing the vulnerabilities in sleep, nutrition, and exercise is no longer a private elective but a professional requirement for the sustainable implementation of SDG #3. By prioritizing the health of the medical workforce, the region can move from merely maintaining a fragile "Low Risk" buffer to optimizing the long-term resilience and leadership capacity of its public health architects.

Table No 3. Relationship between Demographic/ Socio-Economic Profile and Lifestyle

Profile	X^2-value	p-value	Decision	Results
Demographic Profile and Lifestyle				
Age	45.152	0.799	Accept H_o	Not Significant
Gender	23.347	0.667	Accept H_o	Not Significant
Marital Status	68.282	0.842	Accept H_o	Not Significant
Work Assignment	199.883	0.777	Accept H_o	Not Significant
Socio-Economic Profile and Lifestyle				
Education/Specialization	327.312	0.010	Reject H_o	Significant
Job Status/Position	64.105	0.163	Accept H_o	Not Significant
Salary Grade	250.302	0.000	Reject H_o	Significant

Table 3 presents a chi-square analysis examining the relationship between various profile variables and the lifestyle choices of the respondents. In statistical terms, the "Accept Ho" decision means there is no evidence of a relationship, while "Reject Ho" indicates that the variable does influence lifestyle. Demographic factors do not appear to be the driving force behind the lifestyle habits of this group. Age, Gender, Marital Status, and Work Assignment: All these categories yielded p-values significantly higher than the standard 0.05 threshold (ranging from 0.667 to 0.842). Whether a respondent is male or female, young or old, or

working in a specific city or province, their lifestyle remains relatively consistent across the board. These personal characteristics are not significant predictors of health behavior in this study. Unlike general demographics, socioeconomic standing—specifically professional training and financial status—has a direct link to lifestyle. Education/Specialization ($p = 0.010$): This result is statistically significant. It suggests that a physician's specific field of study or medical specialization influences their daily health practices. For instance, those specialized in primary care or lifestyle-focused fields may adopt different habits compared to those in other specializations. Salary Grade ($p = 0.000$): This is the most significant finding in the table. The extremely low p-value indicates a very high probability that income levels and government pay scales dictate lifestyle. This could be due to the resources available at higher salary grades, such as better access to healthy food, fitness facilities, or the ability to manage work-related stress through restorative activities. Job Position ($p = 0.163$): Interestingly, the specific title (MHO vs. PHO) was not significant. This suggests that it is the income (Salary Grade) and training (Education), rather than the job title itself, that shapes how these professionals live.

Table 4. Problems Encountered in Adopting a Healthy Lifestyle

Problems Encountered	f	%	Rank
Lack of time and energy	82	78.8	1
Procrastination ("Do It Tomorrow" Syndrome)	39	37.5	2
Sedentary environment	38	36.5	3
Lack of Motivation and Willpower	35	33.7	4
Unhealthy habits	28	26.9	5
Unavailability of healthy options	12	11.5	6
Lack of support system respondents	9	8.7	7
Insufficient knowledge and training respondents	8	7.7	8
Others: Personal Reasons (Had to take care of dialysis patient at home, Have a pace maker)	7	6.7	9
Peer pressure and social norms	5	4.8	10
Cultural habits	1	1	11

Table 4 reveals that the struggle to maintain a healthy lifestyle is not rooted in a lack of knowledge, but rather in the high-pressure environment and psychological hurdles inherent in health leadership. Lack of Time and Energy (Rank 1: 78.8%) is the primary barrier identified in the study is "Lack of Time and Energy." It is the most overwhelming obstacle identified by the group (rank 1), reported by 78.8% (82) of the respondents. This is the most consistent hurdle found in global healthcare research during the post-pandemic era. As high-level administrators (PHOs, CHOs, and MHOs), these individuals likely face grueling schedules and heavy workloads that leave them physically and mentally drained. This suggests that even with the best intentions, the sheer volume of their professional responsibilities acts as a primary deterrent to personal wellness activities. A 2025 study in the Journal of Interdisciplinary Perspectives found that public sector physicians in developing economies face an "intensity surge" where administrative duties (paperwork/reporting) often bleed into personal time.

Procrastination and Motivation (Rank 2 & 4: 37.5% and 33.7%) were identified as major internal barriers. These barriers also play a substantial role in the group's health struggles. Over a third of the respondents, 37.5% (39), identified Procrastination (the "Do It Tomorrow" Syndrome) as a challenge (rank 2). Recent psychological research from 2025 regarding Behavior Change Support Systems indicates that high-stress professionals often suffer from decision fatigue. After a day of making life-saving decisions, physicians have lower willpower to make personal health choices (e.g., choosing a workout over rest).

Sedentary Environment (Rank 3: 36.5%) was considered as a problem of the medical administrators (PHOs, CHOs, MHOs), the workspace is often more administrative than clinical, leading to a sedentary lifestyle. This aligns with the administrative nature of their roles, which often involve long hours of desk work, meetings, and data analysis. When coupled with the lack of energy mentioned above, the physical environment of their workplace seems to reinforce a cycle of inactivity. Johnson et al. (2023) highlighted that healthcare leadership roles have become increasingly desk-bound due to the digitalization of health records

and remote monitoring. Furthermore, a 2024 review by the Philippine Institute for Development Studies noted that municipal health officers spend over 60% of their day on clerical and coordination tasks. This environment physically limits movement, reinforcing a "Sedentary Environment" that is difficult to break without institutional policy changes.

Only 7.7% cited a lack of training. These leaders know what to do; they simply aren't able to do it. Unlike the general public, these leaders aren't swayed by Peer Pressure (4.8%) or Cultural Habits (1%). They operate in a occupational silo where the demands of the Department of Health far outweigh social influences. Roughly 26.9% struggle with existing habits, such as high caffeine intake or late-night meals, which often serve as survival mechanisms for high-stress roles. As the Philippines shifts toward Universal Health Care (UHC) and preventive medicine, the system must address the "Professional Burnout Paradox." If these 104 leaders are to successfully advocate for community health, the institutional environment must first allow them the time and energy to reclaim their own.

Table 5. Measures Proposed by the Respondents to Address the Problems Encountered

Measures	f	%	Rank
Implement workplace wellness programs	78	75.00	1
Improve healthy food accessibility	72	69.20	2
Set small realistic goals	67	64.40	3
Preventive Screening	51	49.00	4
Create walkable and bikeable infrastructures	47	45.20	5
Community engagement by creating health clubs	46	44.20	6
Comprehensive Education and Training	35	33.70	7
Tailored Digital Tools (Mobile apps)	26	25.00	8
Labeling and advertising regulations	21	20.20	9
Implement subsidies	17	16.30	10
Others: please specify: consistent schedule, daily somatic practice with NLP, innate willpower, healthy lifestyle	4	3.80	11

Table 5 shows that Workplace Wellness Programs (75%), the highest-rated measure in this study is the implementation of institutional wellness programs. The American College of Lifestyle Medicine (ACLM, 2026) emphasizes that workplace wellness is a critical intervention for physician burnout. Their research shows that when institutions provide time for wellness during work hours, clinicians report a 43% reduction in burnout symptoms. Since the 104 respondents previously cited a "Lack of time and energy" as their #1 problem, their call for workplace programs is a direct plea for the organization to "carve out" space for health within the professional schedule. For health leaders in Central Luzon, moving wellness from a personal "after-hours" task to a professional "standard operating procedure" is seen as the most viable solution to the high-stress administrative environment.

The call to Improve Healthy Food Accessibility (69.2%) suggests that while these leaders know what to eat, their physical environment—likely the hospitals or government offices where they work—often lacks nutritious options, making convenience the enemy of health. Improving access to nutritious options addresses the environmental constraints that force busy professionals toward convenience-based, unhealthy eating. Research by Lopez and Chen (2024) on "Food Environments in Healthcare Settings" suggests that "Choice Architecture"—such as subsidizing healthy meals in hospital or government canteens—directly influences dietary quality.

Setting Small, Realistic Goals (Rank 3: 64.4%) addresses the "Procrastination" and "Lack of Willpower" barriers identified in the previous section. The "Micro-Habit Strategy" (2025-2026) has gained traction in behavioral psychology. A study by Santos et al. (2025) indicates that for high-stress professionals, "Small Wins"—such as five-minute somatic exercises or short walking meetings—are more sustainable than ambitious, high-intensity fitness goals. This aligns with the "somatic practice" and "consistent schedule"

mentioned in the "Others" category, suggesting that health officers prefer manageable, incremental changes over drastic lifestyle overhauls.

Nearly half of the participants (45.2%) highlighted the need for Walkable and Bikeable Infrastructure. In provincial capitals like Tarlac and San Fernando, urban design often forces a car-dependent, sedentary lifestyle. By advocating for "Active Design"—such as walkable corridors within government compounds—health officers are seeking to mitigate the sedentary nature of their administrative roles. Tailored mobile apps are seen as a discreet, time-efficient way for high-ranking officials to track recovery and nutrition. There is a recognized need for "Executive Check-ups," as those who care for the public often neglect their own clinical screenings. Suggestions for mental health support and Neuro-Linguistic Programming (NLP) indicate a need for emotional regulation to manage the stress of public health leadership.

Ultimately, these findings show that the health of Central Luzon's leadership is not a matter of individual willpower, but of environmental restructuring. By weaving wellness into the fabric of the professional day, the system can ensure that its leaders remain resilient enough to guide their communities toward a healthier future.

Table 6. Proposed Action Plan for Government Physician Wellness (Central Luzon) by the Researcher

Problems Encountered	Objectives	Tasks or Activities	Criteria (Performance Indicators)	Time Frame	Resources (Budget, Personnel, Equipment)	Expected Outcomes
High reliance on "grab-and-go" meals (High Risk Nutrition)	Shift institutional food culture toward whole-food, plant-predominant options.	Reform canteen procurement to prioritize fresh produce and healthy oils (e.g., olive oil).	50% increase in healthy menu options; 20% reduction in processed snack sales.	6 months (Quarterly review)	Procurement budget; Canteen staff training; Dietician consultant.	Improved Nutrition domain scores; lower systemic inflammation among staff.
Sedentary "Desk-Trap" (High Risk Movement)	Integrate physical movement into the standard workday.	Implement "Stand-Up" or "Walking" meetings; create "Movement Snack" breaks.	80% staff compliance with stand-up meeting protocols.	3 months (Immediate pilot)	None (policy change only); LED timers for meeting rooms.	Reduced sedentary hours; increased aerobic activity baseline.
"Rest Debt" & Burnout (High Risk Recovery)	Reduce systemic "always-on" culture to improve sleep quality.	Mandate "Off-Grid" hours; provide sleep hygiene workshops for staff.	90% reduction in non-emergency after-hours communications.	4 months	HR policy review; Sleep health expert facilitator.	Higher scores in "Refreshed upon waking" and improved stress management.

Leadership Isolation:Need to Improve Connectedness	Reconnect health leaders with organizational purpose and social support.	Establish monthly "Values-Based Leadership" retreats and nature-based briefings.	100% participation in monthly team building/reflective sessions.	Ongoing (Monthly)	Small venue fee; Facilitator/Psychologist; Outdoor venue access.	Enhanced sense of purpose; improved team cohesion and retention.

This action plan is designed as a direct response to the "High Risk" scores identified in this study. It moves the burden of health from the individual physician—who is already overtaxed—to the institution, which has the power to reshape the work environment.

To ensure this action plan remains effective over the next 12 months, establishing a clear Monitoring and Evaluation (M&E) Framework is recommended. This will quantify the impact of the interventions and provide data-driven evidence to the superiors. This framework is designed to track progress from the current baseline (the "High Risk" status) to a target "Low Risk" status across the key domains of Nutrition, Movement, and Recovery.

Table 7. Monitoring and Evaluation (M&E) Framework

Monitoring Pillar	Data Source	Frequency	Performance Indicator
Nutritional Shift	Monthly Canteen Sales Reports	Monthly	Increase in sales of plant-based/whole-food options.
Movement Engagement	Staff Logbook / App Tracking	Quarterly	Increase in "Active Meeting" hours per week.
Recovery Metrics	LMA Follow-up Assessment	Semi-Annual	% increase in "Refreshed upon waking" scores (1.42 to 2.5).
Sustainability (SDG #3)	Key Informant Interviews	Annual	Qualitative feedback on "Sense of Purpose" and morale.

Implications To Public Administration

The implications of this research for Public Administration extend far beyond individual health, framing physician wellness as a cornerstone of institutional stability and economic efficiency. The study reveals three critical shifts necessary for the modernization of the Philippine healthcare system.

1. Strategic Human Resource and Gender-Responsive Governance

With 75% of health leaders in Central Luzon currently in the middle-aged or elderly bracket, the region is approaching a significant "leadership gap." To preserve institutional memory, public administrators must shift from reactive hiring to proactive succession planning, intentionally mentoring the younger 25% of the workforce. Furthermore, since 67% of the leadership is female, governance must become gender-responsive. Utilizing Gender and Development (GAD) budgets to address "time poverty" and the "double burden" of domestic and professional roles is essential. Implementing "Right to Disconnect" protocols and flexible scheduling is not just a benefit—it is a strategic necessity to improve critically low recovery scores.

2. From Disease Managers to Wellness Architects

The research highlights that the "Institutionalization of Healer Wellness" is a prerequisite for the success of the Universal Health Care (UHC) Act. The staggering 78.8% rate of "time poverty" among Municipal Health Officers (MHOs) represents a direct threat to public service delivery. If those at the helm

are too depleted to manage their own health, the entire system's efficiency is compromised. Public administration must, therefore, transition MHOs from being mere "disease managers" to "wellness architects." This requires the Local Government Academy (LGA) to integrate Lifestyle Medicine into leadership training, supported by adequate administrative staffing to offload clerical burdens, allowing physicians to focus on strategic community health.

3. The Health-Economy Link and Administrative Maturity

Finally, the study underscores that physician well-being should be viewed as a "developmental expense" rather than a mere personnel cost. These health officers represent high-value human capital; their burnout leads to "presenteeism" and inefficient resource allocation, which results in a "deadweight loss" for government spending. As the primary "allocators of scarcity" in local budgets, resilient health leaders are better equipped to shift spending toward cost-effective preventive care.

Ultimately, achieving SDG #3 targets for providers is a key indicator of Administrative Maturity. It safeguards the state's return on investment (ROI) and fosters the long-term economic resilience of the Philippine healthcare system, proving that the health of the healer is inseparable from the health of the state.

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