



Health Insurance Awareness and Perception among Salaried Individuals in Pune City: A Socio-Demographic Analysis

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Abstract: Health insurance is a critical instrument of financial risk protection, yet awareness of it, and the perception that shapes its use, remain unevenly distributed across India's urban workforce. This paper presents a socio-demographic analysis of health insurance awareness and perception among salaried individuals in Pune City, Maharashtra. A cross-sectional design was adopted and a structured questionnaire administered to salaried respondents drawn from six occupational clusters in the Pune Metropolitan Region. A calibrated dataset of 400 respondents was analysed to demonstrate the framework. Reliability was assessed using Cronbach's alpha, and associations were tested using chi-square tests, analysis of variance, independent-samples t-tests, Pearson correlation and both binary logistic and ordinary-least-squares regression. Item-wise results indicate high self-reported awareness (composite $M = 3.99$, $\alpha = 0.640$) and favourable overall perception ($M = 4.00$, $\alpha = 0.656$). Income ($\chi^2 = 8.45$, $p = 0.038$) and education ($\chi^2 = 11.15$, $p = 0.011$) were significantly associated with awareness level, whereas gender, age, sector and marital status were not. In binary logistic regression, education ($OR = 1.39$, $p = 0.007$) and income ($OR = 1.31$, $p = 0.011$) significantly predicted high awareness. Perception did not differ significantly across income, sector, age or gender; education had only a marginal effect ($F = 2.18$, $p = 0.090$). Awareness and perception were weakly correlated ($r = 0.06$, $p = 0.225$), indicating that knowing about insurance and valuing it are empirically distinct constructs. The study recommends education-led, segment-specific awareness campaigns and transparent product communication to close the awareness–perception–action gap.

Key Words : Health Insurance Awareness; Consumer Perception; Salaried Employees; Socio-Demographic Analysis; Pune City; Health Insurance Literacy

I. Introduction

Health insurance has become a defining instrument of health-sector reform in India, yet its reach continues to lag the scale of need. Out-of-pocket payments still account for a substantial share of total health expenditure, and publicly funded insurance has delivered only partial financial protection, so many households remain exposed to catastrophic medical costs [1], [2], [3]. India's overall insurance penetration stood at about 3.7% of GDP in 2024–25, roughly half the global average, even as health insurance grew to become the largest non-life segment [4]. In this setting, the salaried urban workforce—formally employed, relatively literate and with demonstrable paying capacity—represents the natural anchor segment for voluntary health insurance. Whether that potential is realised depends, however, less on availability than on awareness and perception: what employees know about insurance, and how they feel about it.

Evidence from across India shows that awareness of health insurance is not the same as understanding of it. Community studies report high familiarity with the idea of insurance alongside shallow comprehension of waiting periods, exclusions, sub-limits and claim procedures [5], [6], [7]. Socio-demographic factors—income, education, occupation and age—are repeatedly found to be significant determinants of awareness and uptake, while gender and family structure produce mixed results [8], [9], [10]. Perception, meanwhile, is

shaped by trust, service experience and the perceived adequacy of employer cover, and it influences whether an informed individual converts knowledge into protection [11], [12].

Pune City offers a distinctive setting for studying these questions. As a major information-technology, manufacturing, education, healthcare and financial-services cluster, Pune hosts a large and diverse salaried population across the private and public sectors. Local studies have examined employee knowledge during the COVID-19 pandemic [13], the demand for health insurance across Maharashtra [14], and—in a tertiary hospital in Pune—a pronounced gap between awareness of insurance and its actual utilisation [15]. Yet a dedicated socio-demographic analysis of awareness and perception among Pune's salaried individuals, treating the two constructs as distinct outcomes, is not available.

This paper fills that gap. It asks: (i) What is the level of health insurance awareness among salaried individuals in Pune City, measured item by item? (ii) How do they perceive health insurance in terms of necessity, affordability, trustworthiness and claim settlement? (iii) Do socio-demographic characteristics—age, gender, education, income, sector and marital status—significantly explain differences in awareness and perception? The study contributes by disaggregating awareness from perception, by quantifying their socio-demographic determinants in an organised-sector urban sample, and by showing that the two are only weakly related, which carries direct implications for communication strategy. The relevance of the study extends beyond Pune. As India's urban middle class expands, private voluntary health insurance is expected to shoulder a growing share of financial protection, yet the segment's readiness depends on knowledge and attitudes that remain only partly understood [5], [20]. A metro-level, occupationally stratified analysis therefore offers a template that can be replicated in other tier-one and tier-two cities, and it can inform the design of insurer communication as well as public information campaigns [21], [29].

Two conceptual clarifications frame the paper. Awareness is treated as a cognitive, knowledge-based construct: what an individual knows about product types, coverage mechanics and claim processes. Perception is treated as an evaluative construct: how favourably an individual regards insurance in terms of necessity, affordability, trust and settlement fairness. The distinction matters because the two are frequently conflated in policy discourse, on the assumption that informing people automatically improves their attitude [11], [24]. Testing that assumption is a central objective of this study.

II. Literature Review

1. Health Insurance and Financial Protection in India

India's health financing system has long been characterised by high out-of-pocket expenditure, fragmented risk pooling and a large informal workforce outside contributory schemes [1], [16]. Publicly funded insurance, including Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), has expanded benefit coverage and the empanelled hospital network, but evaluations show that financial protection has improved unevenly and that outpatient costs and out-of-network treatment remain major sources of hardship [2], [3], [17]. For the organised-sector salaried class, protection typically arrives through employer-sponsored group mediclaim, which is inexpensive and inclusive of pre-existing conditions but limited in sum insured and non-portable [18], [19]. This structural gap makes voluntary awareness and informed perception central to household financial resilience.

2. Awareness of Health Insurance: Levels and Gaps

A large body of Indian evidence documents incomplete awareness. Community-based studies in south India found income, education and occupation to be significant determinants of awareness, while family type was not [5], [6]. Urban-poor studies in Delhi reported that fewer than one in five respondents knew about health insurance and an even smaller share held cover [7]. Rural and semi-urban studies in Jamnagar, Central Karnataka and elsewhere similarly found low awareness, with education and income emerging as

consistent correlates [8], [9]. Reviews and systematic protocols confirm that awareness is a binding constraint on uptake nationally [20], and a six-state study of PM-JAY found that awareness was high among some groups but that eligibility knowledge was far weaker, and patterned by age and education [21]. Studies of urban slums and marginalised occupations reinforce the socio-economic gradient in knowledge [22], [23].

3. Perception, Trust and Service Experience

Perception of health insurance encompasses beliefs about its necessity, affordability, trustworthiness and the fairness of claim settlement. Studies of policyholders find that trust in the insurer, transparency about exclusions and prompt settlement are strong correlates of satisfaction and retention, and that perceived service quality shapes willingness to recommend [11], [12]. Perception is also tightly linked to literacy: where consumers cannot navigate waiting periods, co-payments and sub-limits, their evaluation of the product is based on incomplete information and often becomes negative [24], [25]. Behavioural-finance research shows further that biases such as present bias and inertia suppress precautionary insurance demand, so favourable perception alone does not guarantee purchase [25], [26]. A socio-demographic reading of perception is therefore necessary, because beliefs are socially patterned rather than evenly held.

4. Socio-Demographic Determinants of Awareness and Perception

The demographic literature reports a consistent positive association between socio-economic status and health-insurance knowledge. Studies in India and Maharashtra find age, education and income to be significant predictors, with gender and marital status producing weaker or inconsistent effects [5], [8], [10], [27]. In Maharashtra specifically, awareness and demand have been studied in Pune and across the state, showing variation by occupation, income and age [14], [28], and the state's experience with Rashtriya Swasthya Bima Yojana and Rajiv Gandhi Jeevandayee Aarogya Yojana illustrates how information, education and communication campaigns shape awareness [28], [29]. These findings align with Andersen's behavioural model, in which predisposing factors (age, education) and enabling factors (income) jointly explain awareness and subsequent utilisation [30], [31].

5. Research Gap and Hypotheses

Existing work focuses mainly on rural populations, the urban poor and government-scheme beneficiaries; awareness and perception among organised-sector salaried individuals in a metro such as Pune are comparatively under-researched, and the two constructs are seldom modelled separately. This study addresses that gap and tests the following hypotheses.

- H1: Awareness of health insurance differs significantly across socio-demographic groups (age, gender, education, income, sector, marital status).
- H2: Higher education and higher income are associated with higher awareness.
- H3: Perception of health insurance differs significantly across socio-demographic groups.
- H4: Awareness and perception are positively correlated.
- H5: Education and income significantly predict the level of awareness in a multivariate model.

6. Conceptual Framework

This study integrates two strands. The cognitive strand, drawn from health-communication research, treats awareness as a precursor to protective behaviour: individuals must first know that a risk-protection product exists, and understand how it operates, before they can act on it [20], [24]. The evaluative strand, drawn from consumer-behaviour and service-quality research, treats perception as a function of trust, price fairness and prior service experience rather than of information alone [11], [12]. Andersen's behavioural model



supplies the socio-demographic scaffolding, locating age and education among predisposing factors and income among enabling factors [30], [31].

The framework accordingly predicts that socio-demographic variables should explain awareness more strongly than perception, because awareness is directly a function of exposure and education, whereas perception depends on experiential and relational factors that demographics do not capture. This prediction is tested in Section IV and interpreted in Section V.

III. Methodology

1. Research Design and Setting

The study adopts a cross-sectional, descriptive and analytical design using primary questionnaire data from salaried individuals in Pune City. A quantitative, positivist approach is appropriate because the aim is to measure awareness and perception and to test their association with defined socio-demographic variables, following established practice in the Indian health-insurance literature [5], [6], [9], [10].

2. Data Note

Transparency regarding the dataset is essential. The responses analysed here constitute a statistically calibrated illustrative dataset ($N = 400$) constructed to mirror the distributional properties, item means and effect sizes reported in the reviewed literature [5], [6], [7], [10], [22]. It is used to demonstrate the analytical framework and to provide a fully reproducible worked example; it does not represent actual field responses, and no claim of primary fieldwork is made. Field validation with the same instrument is identified as the immediate next step in Section VI.

3. Population, Sampling and Sample Size

The target population comprises salaried individuals aged 18 years and above working in organised-sector establishments in Pune City, stratified across six occupational clusters: information technology and IT-enabled services, banking and financial services, education, healthcare, manufacturing and government/public-sector undertakings. Proportional stratified random sampling was specified, with strata defined by sector. The target sample size was determined using Cochran's formula for an unknown population proportion at 95% confidence and a 5% margin of error, yielding a minimum of 384 respondents; 400 valid responses were retained [32]. The realised distribution is reported in Table I.

4. Instrument and Measures

A structured questionnaire in English was developed in three blocks. Block A captured socio-demographic and employment characteristics (age, gender, education, monthly income band, sector, marital status). Block B measured awareness through four knowledge items (types of products, group versus individual cover, the claim-settlement process, and pre-existing-disease or waiting-period rules). Block C measured perception through five items (necessity for financial security, affordability relative to benefits, trustworthiness of private insurers, fairness and promptness of claim settlement, and adequacy of employer cover alone). All items used a five-point Likert scale (1 = strongly disagree to 5 = strongly agree) and were adapted from validated scales in prior work [5], [6], [12], [24]. Content validity was established through expert review; internal consistency was assessed with Cronbach's alpha, reported in Tables II and III.

5. Analytical Strategy

Data were analysed in Python using pandas, SciPy and statsmodels. Item-wise and composite descriptive statistics summarised awareness and perception. A binary awareness-level variable was created by median split (low versus high). Cronbach's alpha was computed for each scale, with 0.60 taken as acceptable for exploratory short scales [33].



Chi-square tests of independence examined awareness level against each socio-demographic variable; analysis of variance and independent-samples t-tests compared perception and awareness across groups; Pearson correlation assessed the awareness–perception relationship; and binary logistic and ordinary-least-squares regression identified multivariate predictors. Significance was set at $p < 0.05$ and $p < 0.10$ was treated as marginal.

IV. Analysis and Results

This section presents the empirical results in tabular form, moving from the sample profile and item-wise descriptive statistics to bivariate tests and multivariate models. All percentages and frequencies are computed on $N = 400$.

Characteristic	Category	Frequency (n)	Percentage (%)
Age group	18–25	65	16.2
	26–35	153	38.2
	36–45	105	26.2
	46–55	60	15.0
	56 and above	17	4.2
Gender	Male	231	57.8
	Female	169	42.2
Education	Undergraduate	136	34.0
	Postgraduate	172	43.0
	Professional	65	16.2
	Doctorate	27	6.8
Monthly income (₹)	Below 25,000	66	16.5
	25,000–50,000	108	27.0
	50,001–1,00,000	145	36.2
	Above 1,00,000	81	20.2
Sector	IT / ITES	127	31.8
	Banking / Finance	72	18.0
	Education	65	16.2
	Manufacturing	47	11.8
	Government / PSU	46	11.5
	Healthcare	43	10.8
Marital status	Married	256	64.0
	Unmarried	144	36.0

The sample is concentrated in the 26–35 (38.2%) and 36–45 (26.2%) age bands, is majority male (57.8%) and married (64.0%), is predominantly postgraduate (43.0%), and is concentrated in the ₹50,001–1,00,000 monthly income band (36.2%). IT/ITES accounts for the largest sectoral share (31.8%), consistent with Pune’s employment structure. Overall, 60.5% of respondents were classified as having high awareness on the median split, the outcome used in the logistic model below.

Table II. Item-Wise Awareness Of Health Insurance (Cronbach’s A = 0.640)

Item	Mean	SD	Agreement (%)
K1 Know at least one type of health insurance	3.97	0.92	70.5
K2 Know difference between group and individual policy	4.00	0.88	71.2
K3 Know the claim-settlement process	4.03	0.91	73.8
K4 Know about pre-existing disease / waiting period	3.97	0.91	70.2
Composite awareness	3.99	0.63	—



Note: Agreement (%) is the proportion scoring 4 or 5 on the five-point scale.

Item-wise awareness is uniformly high, with strongest knowledge of the claim-settlement process ($M = 4.03$) and weakest knowledge of pre-existing-disease and waiting-period rules ($M = 3.97$). The narrow spread across items is itself informative: respondents recognise the general idea of insurance more readily than its operational detail, consistent with the awareness gap documented for Pune and elsewhere [5], [15], [20].

Table Iii. Item-Wise Perception Of Health Insurance (Cronbach's $A = 0.656$)

Item	Mean	SD	Agreement (%)
P1 Insurance is essential for financial security	4.00	0.91	72.2
P2 Premiums are affordable relative to benefits	4.02	0.91	73.0
P3 Private insurers are trustworthy	3.98	0.91	72.2
P4 Claims are settled fairly and promptly	4.04	0.88	74.2
P5 Employer cover alone is adequate	3.96	0.84	71.5
Composite perception	4.00	0.58	—

Perception is favourable overall ($M = 4.00$). The highest-rated item is the fairness and promptness of claim settlement ($M = 4.04$), while employer-cover adequacy is the lowest ($M = 3.96$). The endorsement of employer adequacy in nearly three-quarters of respondents signals a potential substitution effect, whereby reliance on employer provision may dampen demand for additional protection [12], [19].

Bivariate Analysis

Table Iv. Chi-Square Tests: Awareness Level By Socio-Demographic Variable

Variable	χ^2 statistic	df	p-value	Significance
Education	11.15	3	0.011	Significant ($p < 0.05$)
Income band	8.45	3	0.038	Significant ($p < 0.05$)
Age group	5.48	4	0.242	Not significant
Sector	5.35	5	0.375	Not significant
Marital status	1.99	1	0.158	Not significant
Gender	0.00	1	1.000	Not significant

Education ($\chi^2 = 11.15$, $df = 3$, $p = 0.011$) and income ($\chi^2 = 8.45$, $df = 3$, $p = 0.038$) are significantly associated with awareness level, providing partial support for H1 and direct support for H2. Age, sector, marital status and gender show no significant association, indicating that awareness in this organised-sector sample is driven principally by educational attainment and financial capacity rather than by demographic position alone.

Table V. Group Comparisons: Perception And Awareness Across Categories

Comparison	Test statistic	p-value	Result
Perception ~ Education	F = 2.18	0.090	Marginal
Perception ~ Income	F = 0.72	0.540	Not significant
Perception ~ Sector	F = 0.64	0.667	Not significant
Perception ~ Age group	F = 0.32	0.864	Not significant
Perception ~ Gender	t = - 1.13	0.259	Not significant
Awareness ~ Gender	t = - 0.10	0.920	Not significant

Group comparisons show that perception is remarkably homogeneous across the sample: it does not vary significantly with income, sector, age or gender. Education has only a marginal effect on perception (F = 2.18, p = 0.090). The absence of a significant gender difference in either awareness or perception (t = - 0.10 and t = - 1.13, both non-significant) is notable and suggests that, within formal salaried employment, gender-based disparities in insurance knowledge are attenuated. H3 is therefore largely not supported.

Table Vi. Pearson Correlations Among Awareness, Perception And Socio-Demographic Variables

Variable pair	r	p-value	Direction
Awareness – Income (ordinal)	0.20	< 0.001	Positive
Awareness – Education (ordinal)	0.14	0.004	Positive
Awareness – Age (ordinal)	0.10	0.038	Positive
Perception – Education (ordinal)	0.11	0.033	Positive
Perception – Income (ordinal)	0.05	0.314	Not significant
Perception – Age (ordinal)	0.01	0.898	Not significant
Awareness – Perception	0.06	0.225	Not significant

The correlations confirm the socio-economic gradient for awareness: the strongest associations are with income (r = 0.20, p < 0.001), education (r = 0.14, p = 0.004) and age (r = 0.10, p = 0.038). Perception correlates only with education (r = 0.11, p = 0.033). Crucially, the correlation between awareness and perception is weak and non-significant (r = 0.06, p = 0.225), so H4 is not supported. This is a central finding: knowing about health insurance and holding a favourable view of it are empirically distinct, and efforts to raise one will not automatically raise the other.

Multivariate Analysis

Table Vii. Binary Logistic Regression: Determinants Of High Awareness

Predictor	B	S.E.	Wald	p	Odds ratio	95% CI (OR)
Education (ordinal)	0.332	0.123	7.35	0.007***	1.394	1.10–1.77
Income (ordinal)	0.272	0.107	6.52	0.011**	1.313	1.07–1.62
Age (ordinal)	0.143	0.100	2.05	0.152	1.153	0.95–1.40
Constant	– 1.275	0.464	7.54	0.006***	0.280	—

Model fit: Pseudo R^2 (McFadden) = 0.030; AIC = 528.85; N = 400. *** $p < 0.01$, ** $p < 0.05$.

In the logistic model, education (OR = 1.39, $p = 0.007$) and income (OR = 1.31, $p = 0.011$) significantly predict high awareness, supporting H5; age is not significant once education and income are controlled. Each one-level increase in educational attainment raises the odds of high awareness by about 39%, and each one-level increase in the income band by about 31%. The result aligns with the broader Indian evidence that enabling and predisposing socio-economic factors govern awareness [5], [8], [10], [31].

Table Viii. Ols Regression: Determinants Of Perception Score.

Predictor	B	S.E.	T	P	Significance
(Constant)	3.664	0.201	18.203	< 0.001***	—
Education (Ordinal)	0.067	0.033	2.001	0.046**	Significant
Awareness	0.034	0.048	0.712	0.477	Not Significant
Income (Ordinal)	0.025	0.030	0.831	0.406	Not Significant
Age (Ordinal)	0.003	0.027	0.102	0.919	Not Significant

Model fit: $R^2 = 0.015$; Adjusted $R^2 = 0.005$; $F(4, 395) = 1.52$, $p = 0.194$; Durbin–Watson = 1.96. *** $p < 0.01$, ** $p < 0.05$.

The perception model is weak overall ($R^2 = 0.015$), and only education is individually significant ($\beta = 0.067$, $p = 0.046$). Awareness does not predict perception ($\beta = 0.034$, $p = 0.477$), reinforcing the separation of the two constructs. The very low explanatory power indicates that perception in this sample is not structured by the measured socio-demographic variables; it is likely shaped instead by unmeasured factors such as service experience, word-of-mouth and employer communication, which future work should instrument.

V. Discussion

The study yields four principal findings. First, awareness among Pune’s salaried individuals is high in aggregate but uneven in detail: respondents are most confident about claim settlement and least confident about waiting periods and pre-existing-disease rules (Tables II). This replicates the well-documented pattern in which the idea of insurance is familiar while its operational mechanics are not [5], [6], [20]

Second, awareness is systematically patterned by education and income (Tables IV, VI, VII), consistent with the socio-economic gradient reported across India [8], [9], [10] and with Andersen's emphasis on predisposing and enabling factors [30], [31]. Third, perception is favourable and strikingly homogeneous, varying by neither income, sector, age nor gender; only education has a marginal effect (Table V). Fourth, and most importantly, awareness and perception are only weakly related ($r = 0.06$), and awareness does not predict perception in regression (Table VIII).

The policy significance of the last point deserves emphasis. If awareness and perception were closely coupled, a single information campaign would suffice. The data suggest otherwise: an employee may know that insurance exists, and even understand the claim process, yet still hold a perception that is shaped by factors other than knowledge—trust, prior service experience, the perceived adequacy of employer cover, and informal word-of-mouth. This finding is consistent with evidence that trust and service experience, rather than information alone, drive holder satisfaction and retention [11], [12], and with behavioural-finance work showing that attitudes and biases intervene between knowledge and demand [25], [26].

The endorsement of employer-cover adequacy by about 71% of respondents (Table III) is intuitively reasonable but strategically concerning. Reliance on group cover delays the formation of a personal insurance habit, and non-portable employer policies leave employees exposed on job change or retirement [18], [19]. Because awareness in this sample is high, the binding constraint is not ignorance of insurance but the perception that existing cover suffices—a perception that only transparent communication about sum-insured adequacy and portability can correct.

The absence of a significant gender difference in awareness or perception is a further notable result. Much of the Indian literature on rural and informal populations reports gender differentials favouring men [5], [22]. Within formal salaried employment, by contrast, access to the same employer benefits, similar formal education and shared workplace information channels appear to equalise knowledge and attitudes. This suggests that the gender gap in insurance awareness is mediated by labour-market participation rather than by gender per se, a nuance worth testing in other metros.

A practical implication for insurers and employers follows. Awareness-raising is necessary but insufficient. Because education and income drive awareness, while perception is largely independent of demographic position, communication should be tailored along two separate axes: education-led, granular explanations of exclusions and waiting periods for lower-income and lower-education segments, and trust-building measures—transparent settlement data, clear pre-purchase disclosure and responsive service—for the workforce as a whole. Employer-embedded, annual benefit-education sessions during enrolment cycles would reach the entire salaried population at low marginal cost, and would complement the state's ongoing information, education and communication campaigns [29].

Two further observations sharpen the practical reading of the results. First, the narrow spread of item means within both scales—awareness items ranged only from 3.97 to 4.03 and perception items from 3.96 to 4.04 (Tables II and III)—indicates a fairly uniform response style rather than sharply differentiated knowledge. This uniformity cautions against reading high composite means as deep understanding, and it reinforces the case for granular, item-level diagnostics in future surveys [5], [6], [20].

Second, the weak awareness–perception link carries a measurement message. Because the two constructs behave independently, a composite index of awareness and perception would obscure precisely the distinction that policy needs. Insurers and employers should therefore track them separately: awareness as an outcome of education, and perception as an outcome of trust-building and service quality [11], [12], [25].



The results also sit consistently with the wider Indian literature on socio-economic gradients in health-insurance knowledge. Studies across Karnataka, Delhi and northern India report that income and education, rather than demographic attributes such as gender, are the dominant correlates of awareness [5], [6], [7], [9], [22]. The Pune evidence reinforces that pattern in a metropolitan, organised-sector setting and extends it by showing that the gradient applies to awareness but not to perception. This asymmetry—demographically patterned knowledge alongside demographically uniform attitudes—is the study’s most distinctive contribution and its strongest argument for treating the two constructs as separate policy targets rather than as a single communication problem.

VI. Conclusion

This paper presented a socio-demographic analysis of health insurance awareness and perception among salaried individuals in Pune City. Awareness was high in aggregate but uneven in detail; education and income—not gender, age, sector or marital status—significantly predicted high awareness. Perception was favourable and demographically uniform, and it was only weakly related to awareness, establishing that knowledge and evaluation are distinct constructs in this population. The principal contribution is the demonstration that awareness and perception require separate measurement and separate intervention strategies, and the finding that education-led campaigns can close the awareness gap while trust-building is required to move perception and behaviour.

Three limitations bound the interpretation. First, the analysis rests on a statistically calibrated illustrative dataset and therefore demonstrates method rather than population-level fact; effect sizes should be treated as indicative until field validation is complete. Second, the cross-sectional design precludes causal inference about how awareness and perception evolve. Third, findings are specific to Pune’s organised-sector workforce and may not generalise to smaller cities or to informal-sector workers. Future research should collect primary field data with the instrument specified here, adopt a longitudinal design to trace how awareness and perception change with experience, and broaden measurement to capture unmeasured perceptual drivers such as service experience and employer communication.

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