CNK

POLICY NOTE

Understanding Barriers to Healthcare Services for North Korean Escapees and Migrant Populations in the UK

2026 SEPTEMBER

North Korean escapees in the UK report intersecting barriers to healthcare use, particularly language barriers, structural exclusion, and limited health system literacy.

EXECUTIVE SUMMARY

Despite the statutory obligations of the National Health Service (NHS) and local authorities to reduce social gradient in health, this community remains at a significant disadvantage compared with other communities. Connect: North Korea (CNK) conducted a cross-sectional study to identify health inequalities compared with three other groups living in the UK, revealing that language-related barriers act as gatekeeping mechanisms that disproportionately exclude North Korean escapees from the healthcare system. A participatory research (PR) approach was employed, incorporating surveys. Participants not only provided data but were also involved in developing research tools, recruiting additional participants, interpreting findings, and formulating recommendations, rather than being solely 'subjects' (Vaughn & Jacquez, 2020). Community input informed the design of questionnaires to address cultural competency, migrant backgrounds, and experiences of health inequalities.

While other groups researched in this study struggle with inconveniences like waiting times, North Korean escapees are more likely than other groups to report barriers that restrict entry into and navigation of the healthcare system. They have limited health literacy and tend to face intersectional barriers to navigating services. These barriers may reduce healthcare use, delay engagement with services, and limit timely access to appropriate treatment. The National Health Service (NHS) and local authorities are required to ensure that health services work for everyone, delivering fair and equal access through collaborative action. This should be implemented at a scale and intensity proportionate to the gradient of health inequality of communities that have been disproportionately marginalised - a principle known as proportionate universalism (Marmot, 2010).

Recommendations include:

1. Empowering the North Korean community by raising awareness about UK health systems and fostering trust-based relationships with healthcare providers.
2. Identifying hidden barriers through data disaggregation, interpreting interactions between ethnicity, migration history, and socioeconomic status (intersectionality).
3. Given that use of AI tools across the NHS is inevitable, data must adequately represent ethnic minorities to enable the identification of meaningful patterns and generation of reliable predictions for both general practice and policymaking.
4. Ensuring improved accessibility so that North Korean escapees can obtain appropriate care when they need it, without structural barriers.
5. Implementing proportionate universalism by offering additional support for communities who face greater disadvantage.

By implementing these measures, local authorities, NHS providers, and national policymakers can reduce structural barriers to care, thereby reducing health inequalities experienced by North Korean escapees and other minority ethnic communities in the UK.

INTRODUCTION

The UK is home to an established North Korean escapee community, which has been concentrated particularly in New Malden, London, since the mid-2000s. Their migration routes include both those who arrived directly in the UK and those who transited through South Korea (Seetzen & Goldsmiths, 2018). The majority of community members supported by CNK are over 40 years old. Internal service use records indicate a growing demand for health-related support within this demographic. However, unfamiliarity with the UK health systems alongside significant linguistic and cultural barriers often discourage individuals from seeking much-needed care. Consequently, many North Korean escapees struggle to navigate resources, access support, and explore available services to them. Health, as a fundamental human right, encompasses not only healthcare access but also the broader Social Determinants of Health (SDoH), such as immigration policies, welfare systems, and structural racism, which shape one's ability to maintain a healthy life (World Health Organization, 2023, 2025). Health inequalities are therefore clear, preventable differences in outcomes that necessitate targeted intervention.

Over the past eight years, CNK has supported the North Korean community primarily in the Royal Borough of Kingston upon Thames through initiatives aimed at fostering resilience and promoting autonomy. Our long-term, devoted engagement has allowed us to document real-world barriers faced by this marginalised community through a foundation of established trust. To better understand these practical challenges in accessing healthcare and maintaining their health, CNK has conducted cross-sectional research over the last two years to determine the specific health needs of this community. Currently, despite the importance of disaggregated data collection and analysis to address each minority group (Kirkby et al., 2023), experiences are often overlooked and underrepresented because of the lack of available data capable of capturing their unique status. To address this, our study compares North Korean escapees with three other groups: South Koreans, white British, and other refugee groups. South Koreans were included as a comparison group to isolate the impact of different migration histories, given that they share similar cultural and linguistic roots prior to the division of the Korean peninsula. In contrast, the other refugee participants, primarily recruited through Refugee Action Kingston (RAK), were included due to their comparable migration routes. Finally, the white British group was included as a majority baseline for comparison, representing the population with the highest level of health system literacy and the fewest cultural or linguistic barriers. This research seeks to propose systemic recommendations for local authorities, healthcare providers, the voluntary sector, and the North Korean community themselves, ensuring that structural barriers no longer delay treatment or hinder their ability to rebuild their lives in the UK.

Ethics and Data Governance

This study was not reviewed or approved by a research ethics committee. CNK conducted this research to better understand the communities it supports. Verbal consent was obtained after explaining the study in the participant's preferred language. All participation was voluntary. Participants were told the study's purpose, how responses would be used, and their right to decline, skip questions, or withdraw at any time. North Korean participants were told their decision would not affect access to current or future CNK services. Questionnaire information was provided in Korean or English as appropriate. For online participants, all information was given at the start of the survey forms. No directly identifying personal information was collected. Findings were reported in aggregated form, and access to the data was limited to authorised research team members. Care was taken when reporting results from small community groups to reduce the possibility of identifying individual participants. These findings are exploratory and community-informed, rather than evidence from a formally approved clinical or academic study.

To our knowledge, there is no existing literature specifically investigating health inequalities among North Korean escapees in the UK, although the country hosts the largest population of North Korean escapees in Europe, primarily concentrated in New Malden, London.

LITERATURE REVIEW

With the exception of the 2018 "Needs Assessment of the Korean Community in Kingston" report commissioned by Kingston Council, the vulnerability of this population remains largely invisible, particularly in relation to its positioning within the broader ethnic health gradient (Seetzen & Goldsmiths, 2018). However, a substantial body of research has examined North Korean escapees resettled in South Korea, consistently reporting correlations between poorer self-rated health, challenges in healthcare utilisation, and longer trauma exposure (Lee et al., 2017; Wang et al., 2014).

A significant barrier to understanding this community's healthcare experiences is the limited visibility of North Korean escapees within routinely collected ethnicity data. The NHS Ethnic Category Code 2001 standard and the standard 20-category Census 2021 ethnic group variable do not include a separate Korean category, although more detailed Office for National Statistics (ONS) classifications can identify Korean ethnicity separately (NHS England, 2024; Office for National Statistics, 2023, 2024). Ethnicity coding in health records is also inconsistent: up to 40% of patients coded as "Any other ethnic group" had an alternative ethnicity code recorded elsewhere in their records (Scobie et al., 2021). An intersectional perspective is essential for understanding these inequalities, as disadvantage often results from the interaction of multiple social positions and structural conditions rather than a single factor (Crenshaw, 1989). For North Korean escapees, ethnicity, migration history, language proficiency, socioeconomic status, and stigma may together shape healthcare access, agency, and health outcomes.

RESULTS

The study included a total of 146 participants, who were categorised according to their self-identified ethnicity and migration background. We surveyed 45 North Korean escapees, 29 South Koreans, 46 white British individuals and 26 individuals categorised as "Other Refugees".

The survey sample (N=146) is small and recruitment used non-probability methods that differed across groups, so estimates are exploratory rather than population-representative and selection or survey-mode effects may contribute to observed differences. On average, North Koreans had been in the UK for over 15 years, South Koreans 7 years, and Other Refugees just below that at 6.7 years. A longer duration of residence, while typically expected to improve familiarity with a new system, was not associated with better healthcare access. North Korean escapees continued to report substantial difficulties navigating the healthcare system and expressed dissatisfaction with services, even after living in the UK for over 15 years. This trend aligned with previous studies of North Korean escapees in South Korea (Lee et al., 2017; Wang et al., 2014), indicating that extended residence alone does not address structural barriers to healthcare. These findings underscore the need for structural reforms to make healthcare systems more accessible and responsive to marginalised migrant and minority populations.

45	29	46	26
North Korean escapees participants	South Korean participants	White British participants	Other Refugee participants

Participant breakdown by ethnic background

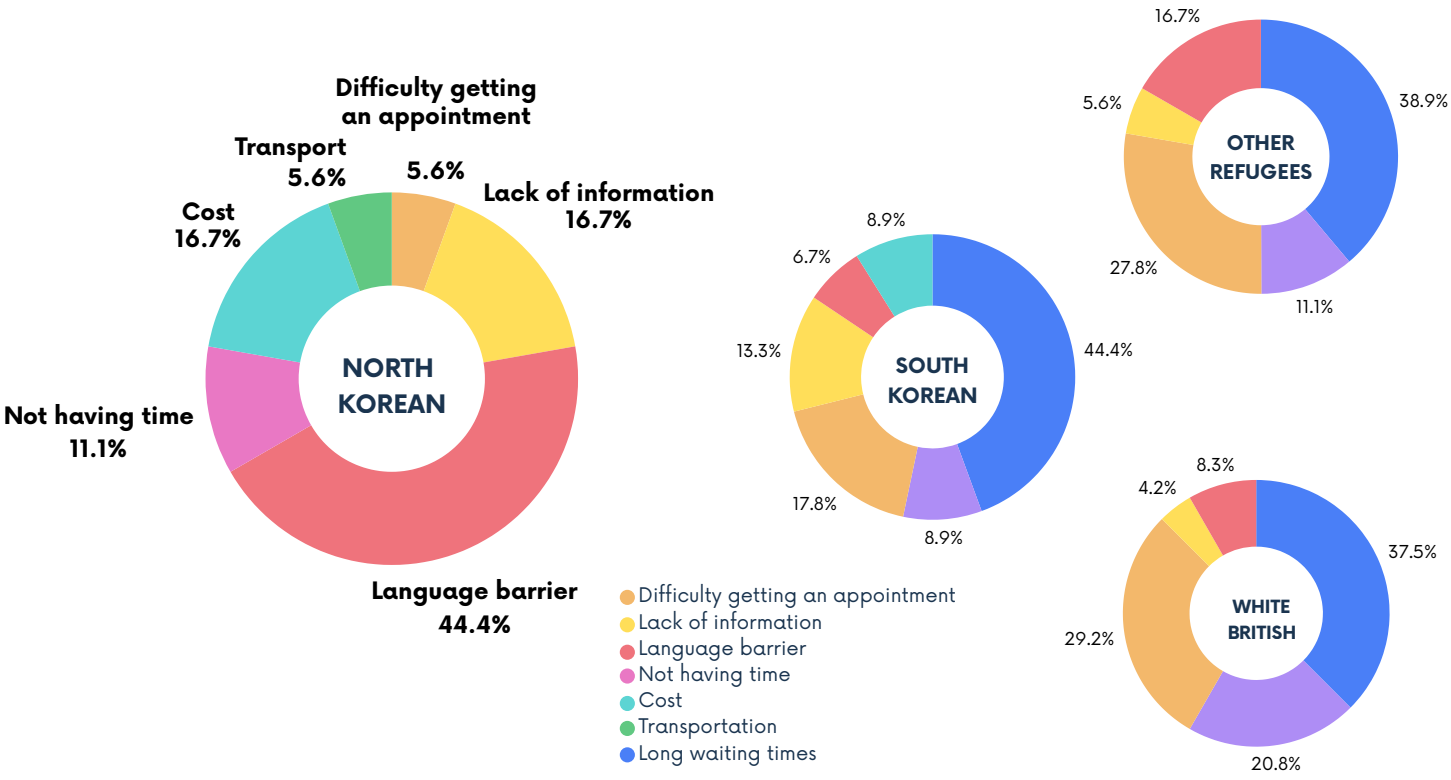
ANALYSIS OF BARRIERS

1. Gateway Barriers: Language and Information

One of the most consistent findings was that limited English proficiency represented a substantial barrier to understanding and navigating the UK healthcare system among North Korean participants. Due to insufficient language support upon arrival and the absence of English education in North Korea, they faced significant challenges when accessing healthcare services in the UK.

Language as Exclusion

While other groups most frequently cited long waiting times as their primary concern, 44.4% of North Korean respondents reported language as their principal barrier to healthcare access. Furthermore, the proportion of individuals affected by language-related barriers was comparatively higher among the Other Refugee group than among the South Korean and white British groups, but still existed. The patterns of barriers observed across groups also suggest that these barriers operate at different structural levels, with different impact sizes. North Korean escapees are often positioned at the margins of the system, struggling with fundamental access and inclusion, whereas other groups tend to experience navigational and procedural challenges within the system.



Information Gaps

Ineffective access to healthcare information significantly restricts participants' ability to navigate healthcare services and resources, undermining their engagement in the treatment process and consequently limiting their agency and autonomy. This structural exclusion appears particularly pronounced among both North and South Korean communities compared to other ethnic groups.

Misinterpretation

Limited health literacy and restricted understanding during consultations further undermine the effectiveness of care and patient satisfaction, and may compound broader exclusion from UK public life. However, these barriers do not operate uniformly; rather, they function through different mechanisms and produce diverse effect sizes, depending on levels of integration into the host society, as well as distinct cultural contexts within and across ethnic groups.

2. Disparities in Health Accessibility and Self-Rated Health (SRH)

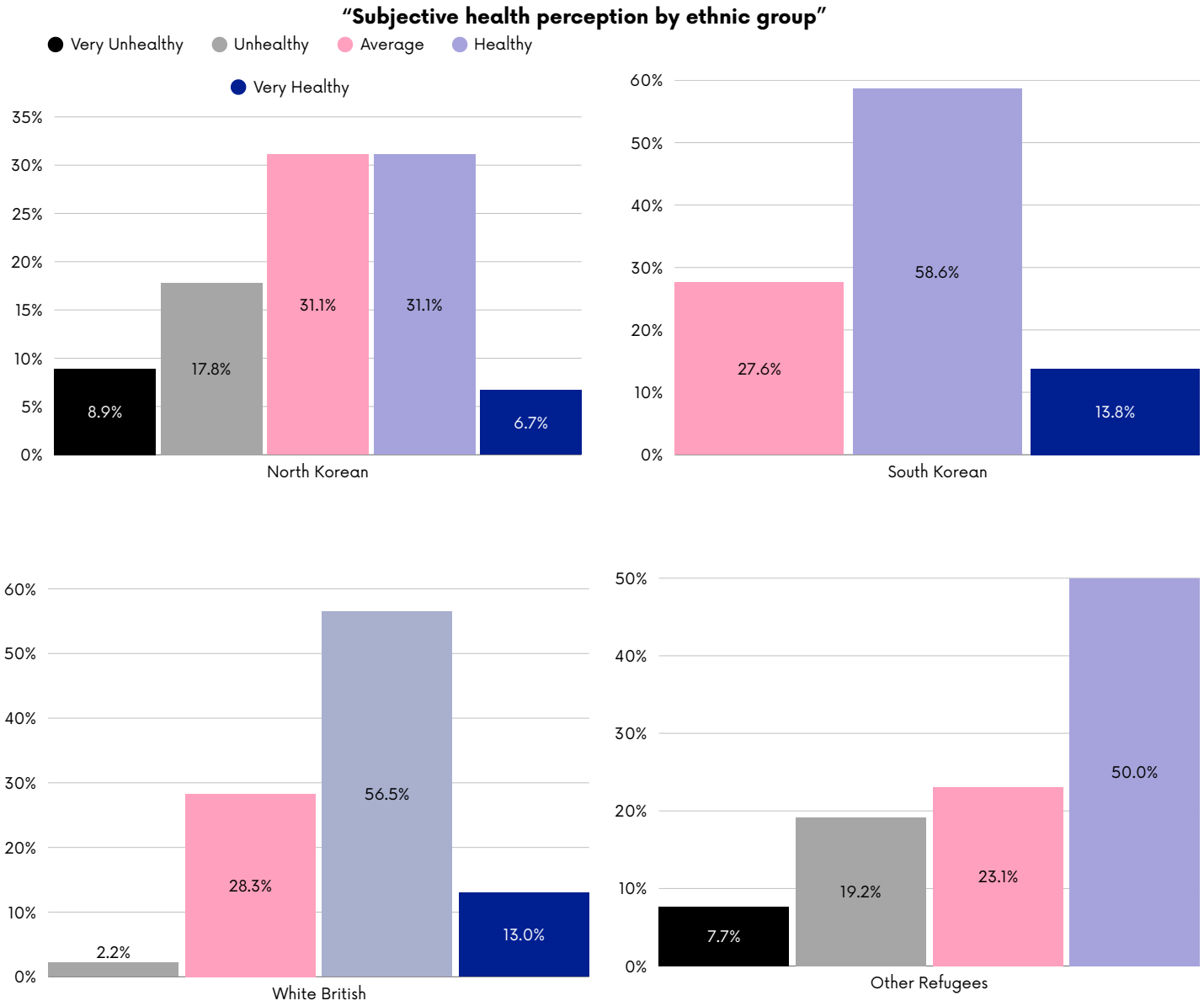
Subjective health accessibility and health perception vary across participant groups, often reflecting broader structural barriers:

Perceived Health

Higher proportions of North Korean escapees and Other Refugees rated their health as "Unhealthy" or "Very Unhealthy", whereas South Korean and white British participants assessed their subjective health positively.

Accessibility

42.2% of North Korean respondents reported that they were unable to access healthcare. Although white British and the Other Refugee group perceived the UK health system as accessible, more than two-thirds of South Korean respondents reported inconvenience in using healthcare services. This finding should be interpreted with caution because healthcare access was assessed using different response formats for North Korean escapees and the other groups, which may limit direct comparability.

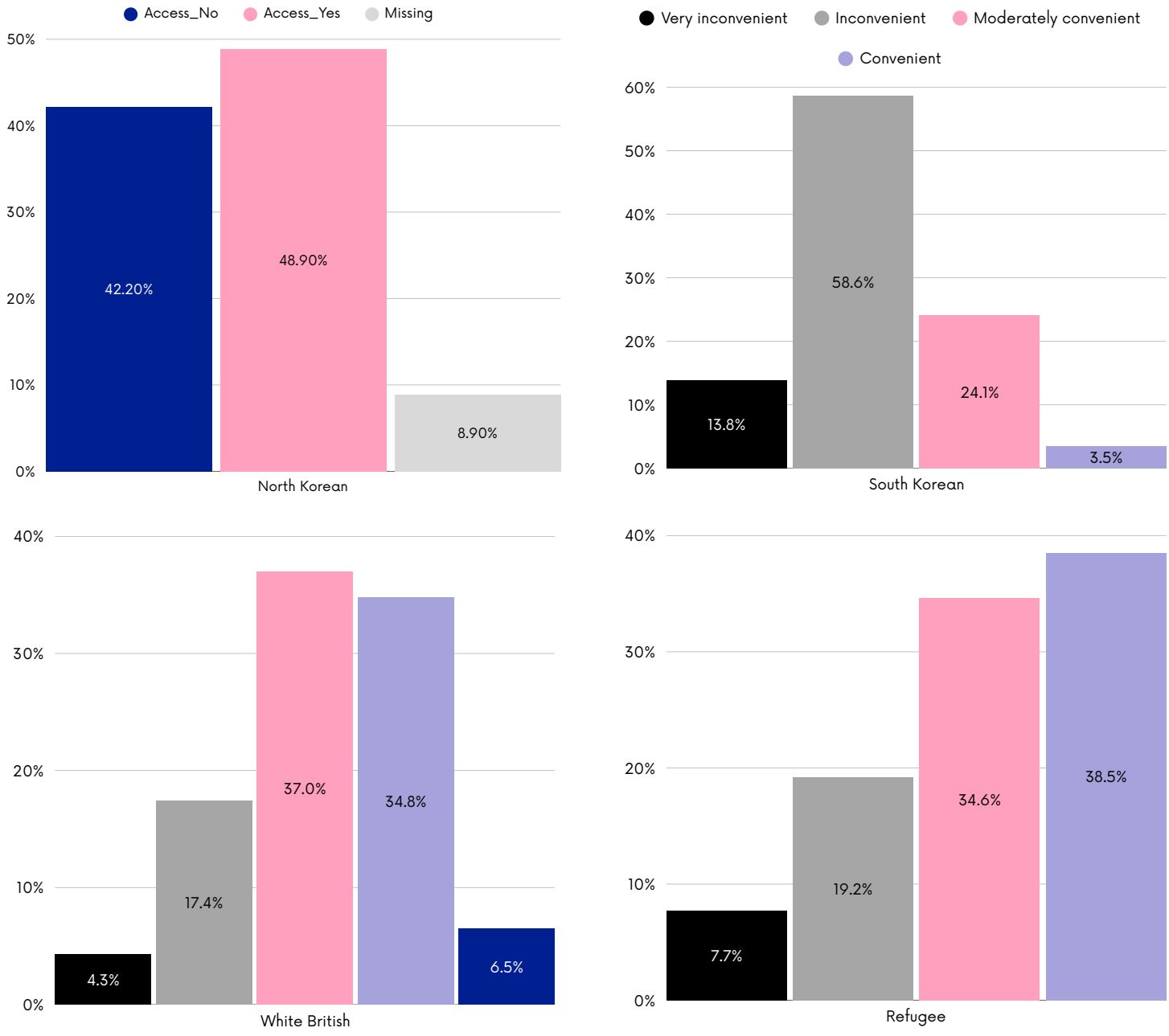


2. Disparities in Health Accessibility and Self-Rated Health (SRH)

Although health accessibility appeared to be related to subjective health only among the Other Refugee group, the remaining groups showed nonlinear relationships. Additionally, no clear pattern was observed between length of residence in the UK and self-rated health in this sample.

These divergent patterns may be explained by culturally shaped and shared standards of subjective health within the communities, differing illness perceptions and health-seeking behaviours, variations in prior experiences with health systems, different levels of health and system literacy, and differential access to alternative resources and sources of support within and outside of the UK health system.

"Perceived accessability of healthcare services by ethnic group"



3. Health Conditions, Comorbidities and the Treatment Gap by Group

In general, North Korean escapees and the Other Refugee group reported relatively higher levels of comorbidity, which implies a higher burden of chronic diseases. The findings also suggest a possible post-diagnostic treatment gap between groups.

Low Treatment Coverage

North Korean escapees had the lowest treatment coverage among participants reporting any diagnosis (58%), compared to 100% among South Koreans and 86% among Other Refugees. Treatment coverage among white British participants was about 60%, similar to that of North Korean escapees.

Across the three measured indicators, North Korean escapees exhibited the most disadvantaged health profile as they reported limited healthcare access, the lowest treatment uptake following diagnosis, and poor self-rated health. However, despite unfavourable health perception, the Other Refugee participants possibly tend to largely rely on healthcare services due to their different health behaviours; thus, the sense of belonging under healthcare coverage may influence their perception of healthcare access.

South Koreans tended to perceive the UK healthcare system as inconvenient to access; nevertheless, they reported relatively high levels of self-rated health and treatment uptake. The results can explain their health-seeking behaviours through findings from prior research (Seetzen & Goldsmiths, 2018), which found that South Koreans travel to their home country for care in a system they are familiar with, or seeks private healthcare services for faster treatment processes.

By contrast, white British participants rated healthcare accessibility most favourably, yet many did not report receiving treatment following diagnosis. Despite lower treatment uptake rates, their perceived health status appeared relatively favourable compared to that observed among the two refugee groups—North Korean escapees and the Other Refugee group—who demonstrated higher or similar levels of treatment uptake. This pattern may reflect a tendency towards self-management or delayed engagement with medical treatment.

This interpretation is corroborated by broader evidence regarding ethnic inequalities in primary healthcare. Magadi and Magadi (2022) identified that variations in patient satisfaction among ethnic groups are primarily associated with service-related factors, such as access to general practitioner services, trust in healthcare professionals, participation in treatment decisions, and the quality of care and concern received. These findings indicate that disparities in healthcare experiences are not attributable solely to patients' individual characteristics.

Health outcomes are not solely determined by healthcare accessibility — they are also shaped by health and health-system literacy, which govern people's autonomy in navigating treatment pathways.

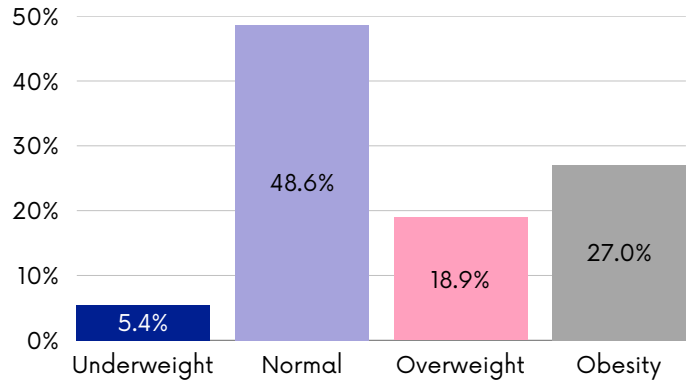
4. Lifestyle factors and tailored support

Physical Activity

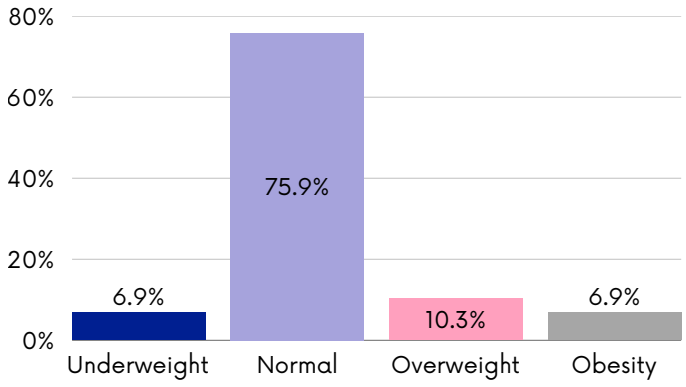
Physical activity participation varied across ethnic groups. Other Refugee participants reported the lowest level of physical activity (52.2%), which was notably lower than that of North Korean escapees (78.6%). North Korean escapees' higher level of physical activity suggests that refugee populations should not be categorised and treated as a homogeneous group in search of intervention for healthier lifestyles. Differences in cultural or gender norms, lived experiences of migration and arrival, and community networks may shape health-seeking behaviours across refugee groups - considerations which should be reflected in the healthcare system.

Obesity Trends

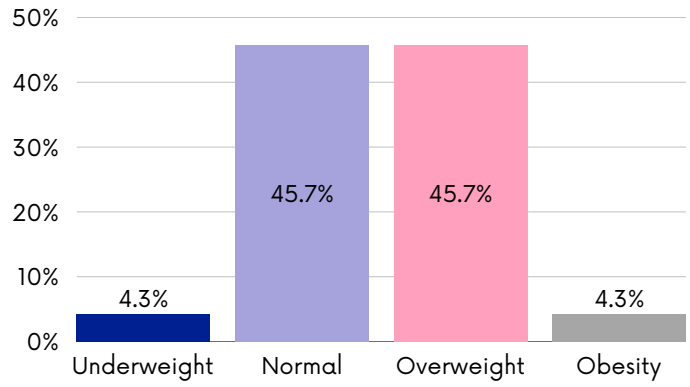
While North and South Koreans and white British participants were more commonly classified within the healthy body mass index (BMI) range, the Other Refugee group showed high rates of obesity and severe obesity. Under the BMI thresholds used in this analysis, the Other Refugee group showed high proportions of participants classified as obese or severely obese. About half of the female participants were severely obese, while 45.5% of male participants were obese. Although male South Korean participants also showed a higher tendency to be overweight or obese, both Korean groups generally fell within healthier ranges under the BMI thresholds used in this analysis. The white British group also showed gender differences in BMI distribution, similar to the two Korean groups: 54.2% of males were classified as overweight, whereas a similar proportion of females fell within the normal BMI range.



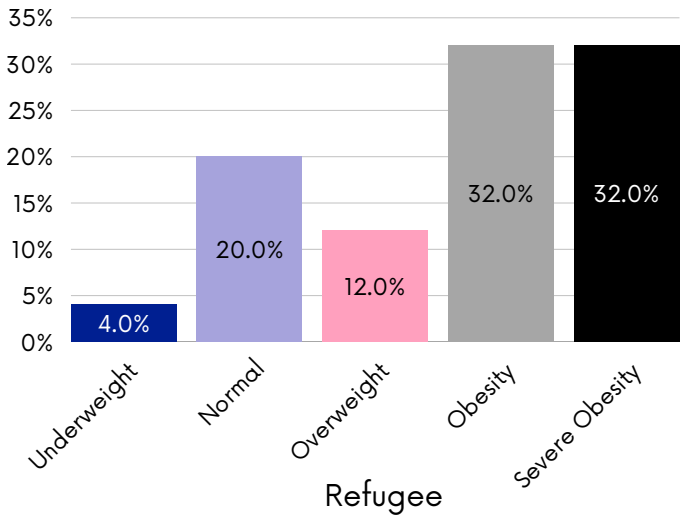
North Korean



South Korean



White British



Refugee

BMI CUT-OFFs

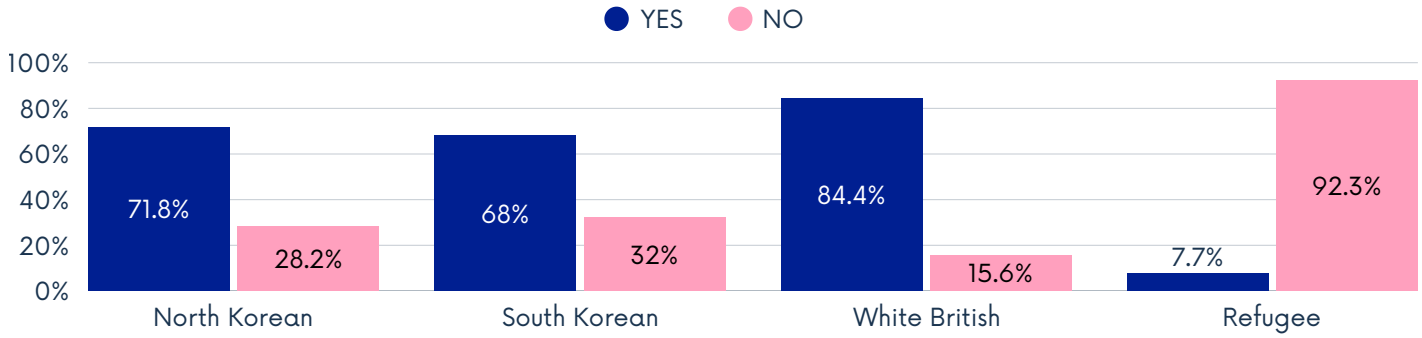
BMI standards (WHO expert consultation, 2004)
Underweight <18.5; Normal 18.5–24.9; Overweight 25.0–29.9; Obesity ≥30.0; Severe obesity ≥40.0
ASIA/PACIFIC:
Underweight <18.5; Normal 18.5–22.9; Overweight 23.0–24.9; Obesity ≥25.0

4. Lifestyle factors and tailored support

Drinking Behaviour

North Korean escapees and South Korean participants show similar patterns of alcohol consumption, suggesting broadly comparable drinking habits (71.8% and 68%, respectively). In contrast, the white British group has much higher alcohol use, with around 84% reporting that they drink, notably higher than North Korean escapees, though this comparison should be interpreted with caution given the small group sizes. The Other Refugee group shows the opposite pattern, with over 90% reporting no alcohol consumption. This finding may reflect cultural, religious, or other social factors that were not directly assessed in this study.

Drinking Habits by ethnicity

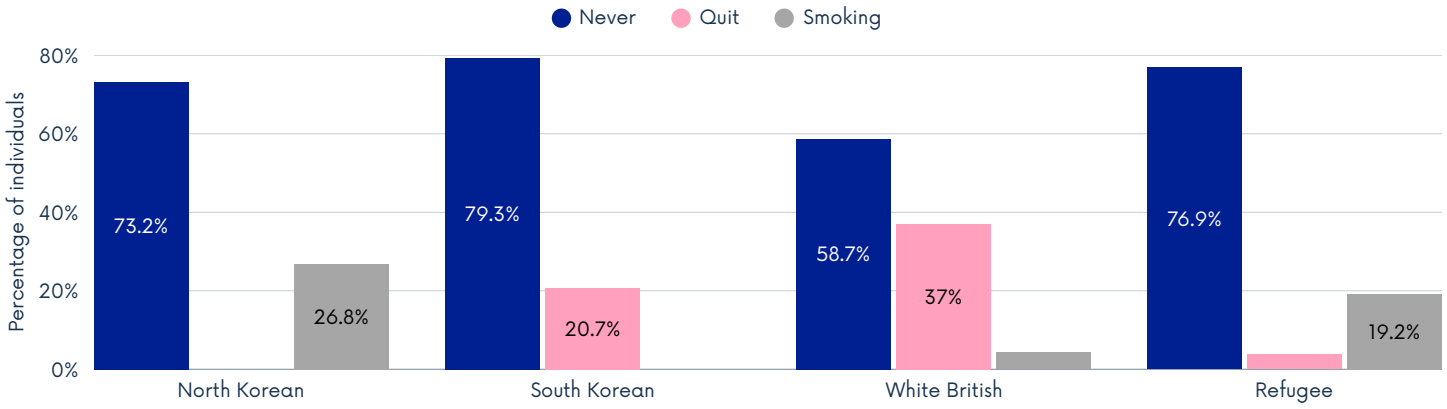


Smoking

Although non-smokers who have never smoked account for the largest proportion in each study group, North Korean escapees and Other Refugees reported relatively higher proportions of current smokers compared with the South Korean and white British groups. This is consistent with broader evidence that migrant health behaviours and outcomes are shaped by socioeconomic conditions and post-migration circumstances (Rechel et al., 2013). Conversely, the South Korean group shows a healthier pattern compared to other migrant groups, suggesting that health-seeking behaviours can vary depending on background within migrant groups.

None of the North Korean escapees had successfully quit smoking, whereas some participants in each of the other groups had successfully quit. Specifically, the non-migrant group, white British, showed the highest number of participants who quit smoking. This may suggest that migration history itself, as well as socioeconomic conditions after migration, plays a large role in shaping health behaviours, even within the same healthcare system. Although this study did not directly assess barriers to smoking cessation, the relatively high prevalence of current smoking in certain ethnic groups underscores the need for structurally supported and culturally adapted smoking cessation interventions as continued smoking is likely to disproportionately affect long-term health outcomes in these populations.

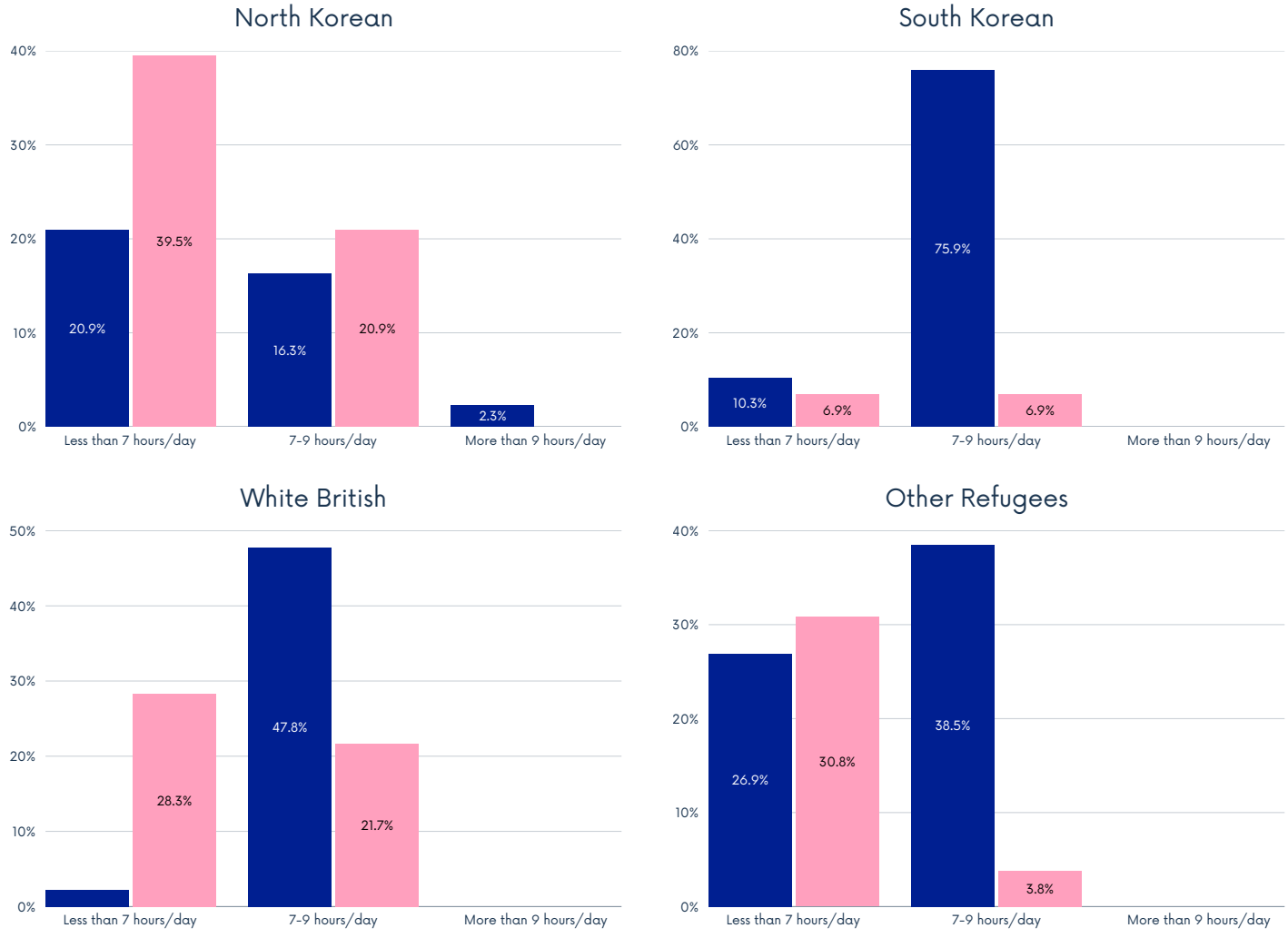
Smoking history by ethnicity



Sleep Satisfaction

Dissatisfaction with sleep is most prevalent among North Korean escapees, even among those who sleep for the recommended duration of seven to nine hours per night; some also reported sleep-related problems such as nocturia, fragmented sleep, and dyspnea. Conversely, sleep satisfaction was generally higher among the remaining groups who slept for a similar duration, especially among the white British group, along with the recommended longer sleep hours (Dzierzewski et al., 2026). This finding suggests that sleep habits are more likely to be related to migration-related trauma, post-migration stressors, limited support, difficulties in accessing services due to systemic barriers, and culturally shaped health-seeking behaviours, which may affect some refugee groups more than others, even when residing in the UK under ostensibly similar conditions. Therefore, it is important to consider ethnic differences when addressing mental health and wellbeing.

"Sleep satisfaction by sleep duration across ethnic groups"



While differences in health behaviours were observed across ethnic groups, these patterns are unlikely to be explained by ethnicity or migration history alone. Consequently, health interventions should not adopt a homogeneous approach to populations.

Instead, differences in health behaviours and healthcare utilisation may reflect broader structural and social factors, including migration experiences, socioeconomic conditions, cultural norms, and community support, which shape how individuals respond to health conditions and barriers to accessing healthcare services.

WHAT CAN BE DONE: RECOMMENDATIONS

This report proposes several recommendations to address the barriers identified in the findings.

AREA 1: Improve Data Granularity and Visibility

MEDIUM PRIORITY

The NHS and the ONS should disaggregate ethnic data in national datasets and administrative records to better capture underrepresented communities, rather than grouping them according to externally defined categories. In particular, this would allow regional Integrated Care Systems (ICSs), including NHS organisations, local authorities, and voluntary and community sector organisations, to identify community needs more accurately and allocate resources proportionately, instead of planning services based on aggregated population groups, which is more appropriate at a national level. Such an approach would not only improve the evidence base for decision-making but also facilitate more effective communication among different stakeholders. This is applicable not just for the North Korean community, but also for other underserved demographics in other areas across the UK.

AREA 2: Enhance Language Inclusivity

HIGH PRIORITY

Local authorities should provide targeted and tailored translation services that respond to the needs of different ethnic groups and extend beyond basic interpretation. Language barriers should not be understood solely as a matter of language proficiency, but as a matter of effective communication within mutual understanding. Therefore, this includes culturally informed communication, community-based health navigation, and programmes that improve both health literacy and health system literacy among migrant communities. The use of complex medical jargon in clinical communication between service providers and users can also create additional barriers, reflecting language barriers even among non-migrant communities who are the most familiar with the health system and have the necessary language proficiency to navigate it.

AREA 3:
Capturing Diversity in Health Data: Foundations for Equitable AI and Policy

FOUNDATIONAL

Building on the data disaggregation recommended in Area 1, accurate, disaggregated data and responsive digital support are essential for equitable adoption of AI-driven tools across NHS services. AI adoption should improve efficiency, patient engagement, and accessibility, while ensuring inclusive, equity-focused implementation to enhance service quality for all. For ethnic minority groups, NHS data collection must go beyond broad ethnic categories. Data systems should capture variables such as previous health system experience, refugee migration history, and health behaviours by ethnic group. This comprehensive information enables providers to predict risks such as untreated health conditions, under-immunisation, and disrupted continuity of care, supporting tailored health services for underserved populations. NHS policy and service design should use this data to co-produce interventions with communities and invest in specialist support services, rather than relying only on generic equity measures.

AREA 4:
Provide Specialised Trauma-Informed Training

MEDIUM PRIORITY

The research findings highlight the need for training opportunities addressing North Korean-specific needs for healthcare providers, local authorities, and policymakers based on deep understanding from research. Such tailored training should address migration-related trauma and adversity experienced by North Korean escapees, as well as the daily barriers that contribute to distrust toward medical institutions, healthcare providers, and the UK healthcare system. When interactions are effective and culturally informed, they can facilitate the successful integration of resettled migrants into the host country beyond the North Korean community. This approach also aligns with the statutory duties of healthcare providers and public authorities to deliver inclusive and culturally responsive care (Equality Act 2010). Overall, investing in cultural competency for North Korean escapees strengthens the organisational capacity of healthcare systems to serve a broader range of minority communities who experience similar forms of social and health service exclusion.

AREA 5:
Adopt Proportionate Universalism

HIGH PRIORITY

Kingston Council and the NHS should implement the principle of proportionate universalism, whereby universal health actions are delivered with an intensity corresponding to the level of disadvantage faced by seldom-heard groups like North Korean escapees. This approach ensures that universal services are available to all individuals while providing additional support for groups facing greater structural disadvantage.

CONCLUSION

CNK's longstanding, trust-based relationship with the North Korean escapee community informed this study's design, recruitment, and identification of community needs. The research used a community-informed participatory approach, incorporating the lived experiences and input of North Korean escapees into questionnaire development.

We conducted multilingual outreach - surveys were developed in two Korean versions (digital and paper-based) and an English version to accommodate varying levels of digital literacy and language preferences.

The health disparities observed among North Korean escapees are not merely the result of individual lifestyle choices but are shaped by structural barriers and a lack of culturally tailored support. In particular, limited language proficiency significantly restricts their access to healthcare services.

These findings demonstrate that equal provision of healthcare and resources alone is insufficient to address entrenched disparities rooted in heterogeneity within populations; an intersectional lens is therefore needed to identify population-specific needs rather than apply a homogeneous approach (Crenshaw, 1989).

Relatedly, poorly disaggregated and inconsistent ethnicity data can obscure health inequalities and hinder the development of targeted interventions (Kirkby et al., 2023; Scobie et al., 2021).

This report highlights the need for targeted policy responses and systemic change to address the specific barriers faced by North Korean escapees in accessing healthcare services and improving their health outcomes, rather than simply expanding service coverage. These findings may also have broader implications for other marginalised communities.

We have five key recommendations as a result:

1) Improve Data Granularity and Visibility

2) Enhance Language Inclusivity

3) Capturing Diversity in Health Data: Foundations for Equitable AI and Policy

4) Provide Specialised Trauma-Informed Training

5) Adopt Proportionate Universalism

Based upon the findings of this report, by implementing these recommendations, local and national stakeholders can begin to address the barriers contributing to health inequalities faced by one of the UK's most marginalised communities.

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