Traders in Nature: Marketing Natural Medicine in 20th-century Britain

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Abstract
Purpose – The purpose of this paper is to present a history of marketing strategies in 20th-century British natural therapeutics, and to discuss conceptual issues in the marketing historiography of alternative medicine.

Design/methodology/approach – Qualitative analysis of archival material and printed primary sources.

Findings – Two marketing strategies prevailed in the early twentieth century. The first one targeted price-sensitive consumers by offering low-price, low-quality substitutes for conventional medical care. This strategy became unviable with the introduction of the National Health Service (NHS), which made conventional medicine free at the point of delivery. The second type of marketing strategy targeted consumers who had the means to use medical doctors but chose not to. Therefore, it proved resilient to the ‘NHS effect’. By the end of the century, complementary medicine served health-related consumer needs but went beyond the simple ‘mending the mind or body,’ or ‘removing disease.’

Research limitation/implications – The paper offers a marketing-based conceptualization of alternative medicine and provides a new interpretation of its historical development.

Keywords – marketing history, complementary and alternative medicine, herbalists, naturopaths, Great Britain, 20th century

Introduction

Alternative medicine is the main provider of natural therapeutics (Wahlberg, 2007). For some consumers, conventional medicine is no longer natural enough. They mistrust synthetic drugs, artificial joints, laser treatments and other fruits of scientific research. This article analyses the marketing strategy of twentieth-century British traders in nature – those complementary and alternative medical practitioners who marketed natural treatment. Traditionally, people have turned to the herb-doctor as the presumed repository of the healing gifts of Nature (All the Year Round, 1888). As time went by, new providers joined in this market niche.

What follows is an overview of the major changes in the marketing of natural-health-related products and services. Traditional market leaders, the herbalists, entered the twentieth century in decline. They were facing two major competitors: patent medicine manufacturers and nature cure practitioners. The introduction of the National Health Service (NHS) in 1948 shook the market structure. Those practitioners who survived were offering a luxury product.

But, first of all, some basic concepts and the nature of consumer demand need to be addressed.

Marketing alternative medicine – conceptual issues

For a historical analysis, ‘alternative medicine’ needs further clarification. The term was coined recently; in Britain, the Times was among the first to use it, under the government of Harold Wilson (Baily, 1975). ‘Alternative medicine’ gradually replaced several expressions of the past: ‘irregular,’ ‘unregistered,’ ‘unqualified,’ ‘heterodox,’ ‘fringe,’ ‘cultish’ ‘marginal,’ or ‘empirical’ practice. Offensive terms abounded, from ‘quackery,’ ‘humbug,’ to ‘charlatanism.’

Most of these terms appeared to be synonyms, or at least to share a common trait. They described a branch of healing that fell outside the medical mainstream. They appeared to express what became later known as ‘alternative medicine’ and ‘complementary and alternative medicine’ (CAM). In marketing terminology, these terms referred to a product category.

Based on its comparatively recent provenance, some medical doctors have even concluded that the term ‘complementary and alternative medicine’ only has meaning in the ‘marketing [of] healthcare ideologies and services’. Moreover, ‘since the terms have no historical bearing whatsoever, [the authors] claim that they are used, together with many other slogans that thrive in contemporary
Western health care, for ideological or commercial reasons to promote ideologies or to facilitate the selling of products and services’ (Louhiala and Puustinen, 2012). This can be construed as an argument in favour of marketing historiography.

Others have tried to draw distinctions between the terms based on consumer behaviour. Complementary therapies have been supposedly used and practiced alongside conventional medicine; alternative medicine instead of conventional medicine (Baer, 2004, p. xiv). The combination of both terms has been considered politically correct. It became de rigueur in the late 1980s: in May 1987, the Journal of alternative medicine became the Journal of alternative and complementary medicine. Industry realities, however, were less clear than the vocabulary suggested.

The terms ‘complementary’ and ‘alternative’ correspond to core economic concepts and have therefore misled many economists. ‘Complementary medicine’ suggests a relationship of complementarity, and ‘alternative medicine’ that of substitution.

But the true nature of the relationship between CAM and conventional medicine needs to be tested empirically. There are three possibilities: they are substitutes (controlling for changes in consumers’ income, a price increase in conventional medicine increases the amount of alternative medicine consumed), complements (controlling for changes in income, a price increase in conventional medicine decreases the amount of alternative medicine consumed), or they are independent (controlling for changes in income, a price increase in conventional medicine has no effect on the amount of alternative medicine consumed) (Samuelson, 1974). Some empirical studies suggest that alternative medicine rather acts as a complement to conventional medicine (Murray and Shepherd, 1993, Burstein et al., 1999).

A study of the marketing of natural therapies is therefore a study of ‘alternative specialists’. In medical history, alternative medicine is often credited for discovering specialisation, or at least for showing medical doctors what they could gain from specialising. In traditional accounts, medical specialists would differ from the alternative one, not only by having a medical degree, but also by showing public spirit and a concern for the advancement of science (Rosen, 1942, Peterson, 1978, p. 260).

From a marketing perspective, there appears to be a more fundamental differentiation. Conventional specialists have focused on specific organs or diseases. Even in the twentieth century, consumer demand was no concern of theirs. As a psychiatrist put it:

I do not accept that what the public wants must be necessarily for the public good. There is too much evidence to the contrary; alcohol, drugs, gambling and promiscuity are obvious examples. Medicine does not cater for public demand; it is frequently its duty to resist such demands (Sim, 1975).

Alternative specialists, in contrast, served consumer demand that went beyond the simple ‘give me treatment for this.’ They did not focus on a technology of disease removal. Instead, alternative specialists offered products and services essential to human well-being, for example those related to ‘nature’.

The nature of consumer demand for natural cures
Nature has always had a place in healthcare. Health appears to be the natural state of the human body; nature and healing have been inextricably linked since Hippocrates. Disease is a deviation from the norm. It is more than just a malady – it is a signal that the body is restoring its balance. Recovery is natural. It is the work of Nature (Neuburger, 1944). Sometimes, nature needs some help. It would be dangerous to leave it alone – death is natural, too. ‘The problem of the natural healing power of nature is a great, perhaps the greatest of all problems which have occupied the physicians for thousands of years,’ writes a medical historian. ‘The doctrine of the natural healing processes […] is drawn as a red line through the history of medicine’ (Neuburger, 1933).

If nature indeed needs help, this is the role of healers. They help the patient find that extra bit of nature that will bring health. The demand for their wares is greater if patients feel out of touch with nature, for instance because they live in an advanced industrial society. Indeed, natural health values are of counter-modernist descent. Consumers yearn for a natural order that they see as lost or endangered (Thompson and Troester, 2002).

Some omissions in this paper are necessary, though. Were the complementary therapies discussed here effective? In the absence of retrospective clinical trials, it is impossible to tell. Did alternative
The divided house of herbalism – the two marketing strategies

Herbs have always lain at the core of the herbalist’s activities. Being a natural product, however, they could be dealt with in several ways. This, in turn, has led to differentiation among herbalists. In terms of their marketing model, early twentieth-century herbalists could be roughly divided into two groups.

One emphasised the supply of herbal products, the other the provision of professional services connected to herbs, e.g., prescribing. The former group sold cheap medicine (thereby competing on price). The latter sold natural medicine which they claimed had no side-effects (thereby competing on quality). Closely related were divisions based on sales strategy. There were different groups of practitioners: itinerant herbalists, backstreet herbalists, and medical herbalists.

Travelling herbalists formed the lowest echelon of the herb business. A government report described them as ‘partaking largely of the nature of the itinerant quack’ who sold their remedies in markets or hawked them from door to door (Report as to the practice of medicine and surgery by unqualified persons, 1910, p. 6). The same source acknowledged how difficult it was to estimate the travelling herbalists’ number. It is safe to assume they were disappearing like other itinerant unorthodox practitioners. They appeared to ‘prevail largely in the country districts’.

Urban areas were the domain of backstreet herbalists – shopkeepers. Some anecdotes about this group of practitioners survive. According to one herbalist’s memoirs, herbal shops were usually situated in poorer neighbourhoods. This was dictated by convenience to customers and the lower rents. ‘Of course the overheads were low in the back streets, and, besides, they were not far from residential areas where it was safe to send children for the odd household remedy.’ These backstreet herbalists did not have consulting rooms and patients were seen over the counter (Orbell, 1980). In other words, they were retailing agricultural products rather than health advice. This hurt their profits. According to basic microeconomics, raw products such as herbs are undifferentiated goods and cannot be sold above the market price.

Herbal shops were consequently operating on a slim margin. As described by a herbalist, ‘it was necessary to sell all kinds of things to supplement the meagre income.’ For example, most shops sold medicines produced by major pharmaceutical companies such as Beecham (Orbell, 1980). Facing imminent ruin, some shop owners diversified into unrelated merchandise. The Bankruptcy Courts proceedings (The Times, 1924, The Times, 1933, The Times, 1939) show just how inventive herbalists could be – while many remained true to their core business others started selling newspapers, soft drinks, and confectionery.

The self-styled elite of botanic medicine were the herbalist consultants with herbal dispensaries, the “herbal GPs,” or medical herbalists, as they preferred to be called. An official investigation found that in some parts of Britain the herbalists were ‘stated to have a higher reputation than qualified men’ (Report as to the practice of medicine and surgery by unqualified persons, 1910, p. 11). The same inquiry established that the herbalist business appeared ‘to be a lucrative one.’

This was corroborated by Joseph Watmor, a practising herbalist testifying before a Parliamentary Select Committee on Patent Medicines (Report from the Select Committee on Patent Medicines, 1914, p. 618, Q.11607). The most reputable herbalists, he said, would see as many as 40–50 patients a day and were earning, before the First World War, from £300 to £500 a year. In terms of their income, these elite herbalists were thus on a par with higher professionals. At that time, an average general practitioner would have earned £395, a dentist £368, and a barrister £478 a year (Digby and Bosanquet, 1988).

In spite of its emphasis on service, medical herbalism was developing under a technological/material constraint. Herbalists had to rely on herbs. Herbs were their unique selling proposition, but also their weakness. Herbs have been subject to adverse regulation, cut-price competition by synthetic drugs and, like every natural product, to seasonal supply-cycles.

These differences between herbalists were fueling conflicts. Service model herbalists were embarrassed by the backstreet herbal shop-owners. While the former branded themselves as modern professionals, the latter conjured images of backwaters and superstitions. They operated from little shops in the East End, wore white beards and cured blisters by blowing on them. They were saying spells and selling love potions – all according to a newspaper article, ‘Magic in London’ (The Times,
As a socialite lady recalled, ‘in so many people’s minds […] a herbalist’s shop inevitably meant a small shabby room with dirty windows, dingy walls, and dusty shelves littered with rubbish, all suggestive of mysterious and probably evil practices’ (Leyel, 1943, p. 28).

The bad reputation of the backstreet herbalist blemished that of the medical herbalists as well, especially since the former outnumbered the latter. It was estimated that 1,500 herbalists kept open shops, while The National Association of Medical Herbalists (NAMH, an association of high-quality providers) had around 200 members (Report from the Select Committee on Patent Medicines, 1914, p. 619, Q.1167, p.612, Q.11456).

It was a chain of herbal stores, though, that reached out to the upper-class market – Culpeper. Even though they specialised in herbs, Culpeper stores were the antithesis of backstreet herb shops which largely relied on a price-conscious, working-class customers. Named after the seventeenth-century herbalist Nicholas Culpeper, these stores offered a shopping experience which enabled them to charge a price premium. Herbs and herbal products were displayed ‘in an agreeable and attractive setting that would immediately convey an impression of modern hygienic cleanliness’ (Leyel, 1943). They operated from prestigious locations such as London Mayfair, Baker Street, and Knightsbridge, or Bath and Brighton. The shops were run by the Society of Herbalists which was a trading and consumer education group rather than a professional association. Its advisory committee demonstrated the social standing of the Culpeper clientele – it was chaired by the Marchioness of Londonderry and included the Duke of Abercorn as well as several countesses and generals (The Society of Herbalists, 1935?).

This business strategy was in many aspects the reflection of the founder, Hilda Winifred Leyel, who opened the first shop in 1927. Her obituary would later describe her as a ‘woman of much charm and great practical ability.’ After a short career in acting, she turned into a London socialite and organised fancy dress balls. ‘Subsequently Mrs Leyel hit on the highly successful idea of introducing the prescriptions and doctrines of the old herbalists to a modern, a principally feminine, public. On these she wrote fairly frequently, but not without sometimes revealing her lack of scientific botanical training’ (The Times, 1957).

Culpeper stores stressed their differences with other herbalists. The National Association of Medical Herbalists took great offence at an article published by Lady Simson, a member of the Society of Herbalists. She claimed that it was her society that was making herbalism scientific, whereas other herbalists practised behind worm-eaten counters. In 1932, the Medical Herbalist published a rebuttal. ‘You do not find the “dirty, stuffy little shop,” but a well-equipped dispensary and consulting room.’ Moreover, medical herbalists were proud of the achievement within their ranks. ‘We cannot boast any of them holding a knighthood, but amongst our members have been mayors of important cities, town and district councillors’ (Yemm, 1933).

Nonetheless, it was difficult for medical herbalists to signal their quality. One method was to emulate the medical profession – write letters after one’s name denoting qualifications and professional memberships. The medical establishment was bemused and took this practice for yet another proof that herbalists were selling inferior substitutes to conventional healthcare. Commenting upon an annual conference of a certain Society of United Medical Herbalists of Great Britain, a very orthodox medical journal noticed the herbalist titles such as MDBc, FSSc, MPS, or MBBC – they ‘had the charmingness of variety and of vagueness’ (Lancet, 1894). Arguably the most effective signals of quality – the medical titles – were restricted by law to members of the medical profession.

The competitive pill

While herbalists were seeing their main foe in orthodox physicians (perhaps bounded by their aspirations), more serious challengers arose in the form of patent medicines.

Patent medicines were over-the-counter products. The ‘patent’ referred to their trademarked names rather than their substance. These medicines were sometimes called proprietary or secret remedies, since their ingredients were guarded as secrecy. The business historian Stanley Chapman suggests patent medicines sales captured the rise in working-class disposable income. Buyers were anxious about health but could not afford the services of a medical doctor. Moreover, their growing literacy made them susceptible to unregulated advertising (Chapman, 1973). The claims put forward did not appeal to the working classes only. ‘Not only are they largely purchased by the poorer classes, and consumed in enormous quantities, but the well-to-do have recourse to them in a large measure,’ was reported to the Privy Council (Report as to the practice of medicine and surgery by unqualified persons, 1910, p. 11).
Producers nonetheless focused their marketing efforts on the mass market. In 1912, most advertisements were placed in half-penny dailies (British Medical Association, 1912, p. 253). Such media buying continued after the war (Clark, 1938, p. 27). Advertising even intensified, which suggests that demand was hurt by the economic depression. In 1936 alone the proprietary medicine industry spent £2,500,000 on press advertising (Turner, 1952, p. 203).

By as early as the latter reign of Queen Victoria, the patent medicines industry had become a competitor to be reckoned with. Patent medicine vendors were sometimes using the same sales-pitch as the herbalists. They claimed to be harmless and the truly beneficial natural medicine. The Veno Drug Company for example sold a ‘Seaweed tonic.’ Beecham’s Pills claimed to be ‘a vegetable compound’ (Phillips, 1910, p. 30). The latter product was the market leader with 250 million pills produced in 1890s. The output rose to 308 million in 1915 and was approaching 500 million in the early 1920s (Corley, 2003).

A few herbalists marketed their own patent medicines. Some herbalists were declared patent medicine vendors for tax reasons. In 1932, a Police Court fined the Society of Herbalists for selling unstamped herbal products in their Culpeper stores while advertising their curative properties (The Times, 1932). Others decided to enter the business. Such was the case of big wholesale dealers who dominated the agricultural market for herbs (The Times, 1916). These firms bought herbs from growers and collectors, turned some into proprietary products, and sold raw herbs to retail pharmacists, small shopkeepers, and herbalists. In the interwar era, prominent wholesale firms included Hirst, Brooke and Hirst of Leeds, Brook Parker & Co of Bradford, and Potter and Clarke’s (Stobart, 1998). In 1935, their interest group, the Association of Wholesale Druggists and Manufacturers of Medicinal Preparations, had an estimated 35 members (Representations to the Ministry of Health on the Medical and Surgical Appliances [Advertisement] Bill, 1935). Wholesale herb traders were cultivating their natural image. Potter and Clarke’s had close ties with the National Association of Medical Herbalists. It endowed an award for the Association’s best students – the ‘Henry Potter prize’ (NAMH, 1944).

In the early twentieth century, herbalists were facing growing competition. To use a military metaphor – they were under attack on two fronts. They were pushed out of the working-class market by price-cutting patent medicines. They could not advance into the upper-class market because the position of natural therapeutics was already occupied by nature cure practitioners.

**Nature cure’s up-market targeting**

In high-income markets, the demand for natural healing was served by naturopaths, or nature cure practitioners, as they were sometimes called. Their marketing strategy revolved on promoting a healthy lifestyle. Since nature cure emphasised its philosophical underpinnings, it was vulnerable to splitting up along dogmatic lines. The differences revolved around the question what ‘natural’ was. While many naturopaths rejected herbal remedies as ‘unnatural’ they were happy to adopt electromagnetic blankets, radiant heat, and artificial sunlight (Benjamin, 1936, p. 76).

Naturopaths claimed to cure diseases by stimulating the patients’ ability of self-healing. To achieve this, they prescribed a diverse regime that could range from regular physical exercise to sun-bathing, fasting, vegetarianism, and receiving enemas. These practices sometimes involved a complete change of lifestyle. This was only achievable by discipline and constant awareness of one’s actions, at high cognitive costs. When you had to re-think every daily habit, you could spend less time thinking about something else, for instance about earning money or relaxing with your family. Such costs were a major obstacle to the popularity of naturopathy. As an editorialist in a nature-cure consumer magazine admitted (Nature Cure Magazine, 1929), naturopathy lacked that “‘touch the button’ idea of doing things’ and insisted upon ‘discipline in all of its health restoration and maintenance teachings.’

Conversely, the main selling proposition of naturopathy lay in its universality. It claimed to stimulate the healing force of nature and this had no limits. It was a cure-all. Naturopathy was even more than medication; it was a philosophy. As a textbook put it, ‘Naturopathy is a way of life as well as a system of healing’ (Hewlett-Parsons, 1968, p. 19). British consumers accepted nature cure because it merged several existing lifestyles. Medical historians identify its roots in several nineteenth-century movements – water cure, vegetarianism, American health reform, and phrenology (Brown, 1988).

Nature cure was a luxury treatment that treated the adverse effects of affluence. ‘People suffer more from gluttony than from a restriction of food,’ wrote a naturopath (Maxwell, 1934). He was hardly referring to the working classes. The high adoption costs of naturopathy, both monetary and cognitive, were prohibitive for mass marketing. Naturopaths were condemning the use of medicines and relied on a diet of fresh fruit and vegetables instead.
Such foodstuff was out of reach for low-income families. In the 1930s, they still spent as much as 50% of their budget on food (Boyd Orr, 1936, p. 21). For them, spending extra money on wholesome nutrition would have meant cutting down on fuel or clothing. Already malnourished, they also resented naturopaths’ other preferred method – fasting. George Orwell discussed working class diet in *The Road to Wigan Pier*. ‘The ordinary human being would sooner starve than live on brown bread and raw carrots.’ Naturopathy was for the well-to-do. ‘A millionaire may enjoy breakfasting off orange juice and Ryvita biscuits; an unemployed man doesn’t’ (Orwell, 2001, p. 161). When the magazine *Health for All* claimed the contrary, an outdoor worker begged to differ:

I agree that there is a lot to be said for the Nature Cure practitioner, but when one has to bring up a family of four on a wage packet of £3 6s. and desires treatment from a Naturopath 35 miles away whose consulting fee was £2 2s. plus 10s. for advice, not counting loss of work, it is, to say the least, prohibitive (Jones, 1945).

Naturopathic practitioners were providing various services — from giving enemas to advising on nutrition. What they did not do was dispense drugs or other health products. Naturopaths were not concerned with naturopathic merchandise which was instead supplied by health-food shops. These appeared in larger towns from about 1923 onwards and sold products such as dried fruits, herb teas, nuts, or cereals (Burnett, 1979, p. 293). By the late 1920s, they already numbered an estimated 500 (Hill, 1998). These businesses catered for a variety of lifestyles that in many cases overlapped with the nature cure movement, for example vegetarianism. They were, moreover, a source of over-the-counter health advice in their own right. It was only in 1935 that a major producer and catalogue-retailer of health foods, Pitman, acknowledged the division of labour between shops and naturopaths. Health advice should be left to ‘much abler hands’ of nature cure practitioners, while Pitman would provide the particular food ‘in the best possible form’ (Hill, 1998, p. 182).

Masquerading as food, health products escaped pharmaceutical regulation. They also circumvented naturopathic dogma which banned any medication. Even the otherwise strict naturopathic magazine *Health for All* accepted advertisements for over-the-counter preparations – provided it was claimed they were not medicines. ‘Natex is not a drug,’ assured the producer in the 1940s, ‘it is a slimming food which re-invigorates your thyroid gland and makes it able to deal with all the fat-making foods you eat’ (Natex “Five” [advertisement], 1945).

Naturopathic practitioners, in contrast, focused on ‘teaching’ their patients to heal themselves. ‘The word “doctor” means teacher,’ wrote a 1920s naturopath, ‘and the most important part of a Nature Cure practitioner’s work is to teach’ (St John Doherty, 1929). The barriers to entry were hence small and the services offered were easy to imitate. After they had gained some experience, patients could use naturopathic treatments on their own, without any greater risk (Regin, 1995). The elite amongst them owned sanatoria as a continuous source of income. To ensure differentiation and steady income the profession focused on providing spinal manipulation. ‘Most Naturopaths – although disagreeing fundamentally with osteopaths and chiropractors as to the origin and nature of disease – use both these methods in their work,’ wrote a 1930s practitioner (Benjamin, 1936).

By broadening the range of their services, naturopaths based their appeal on offering a one-stop-shop health solution. They were alternative medicine in miniature. This produced tensions with existing osteopaths who considered naturopaths to be low-quality imitators. Such tensions persisted after the Second World War (Dummer, 1963).

The increasing reliance on osteopathic and chiropractic methods, as well as on ultra-violet light, increased regulatory and reputational risk. It is worth noting that by the late nineteenth century, ‘massage’ had become a euphemism for prostitution (Barclay, 1994, p. 12). Those naturopaths practising in the metropolis had therefore license requirements imposed on them by the London County Council. The origins of these regulations dated back to 1913. The Commissioner of Police expressed his concerns that ‘many of the establishments in the West End of London which advertised massage, manicure and electrical treatment were really disorderly houses’ (Gibbon and Bell, 1939, p. 564). In 1915, the Council received powers to register such houses. Failing to curb prostitution, registration was replaced with stricter licensing in 1920.

What was created to prevent immorality was soon expanded to check alternative medical therapies – described by the official historians of the London County Council as ‘harmful, unskilled or unqualified treatment’ (Gibbon and Bell, 1939). Ultra-violet treatment was to be administered only when prescribed by a registered medical practitioner. Naturopaths tried to challenge this requirement
in courts but failed. In 1936, the Marlborough Street Police Court Magistrate ruled that London licensing regulations were reasonable. The magistrate accepted the opinion of two medical witnesses that naturopaths ‘were not qualified to diagnose tuberculosis and give ultra-violet ray treatment without proper medical supervision’ (The Times, 1936). This decision undermined naturopaths’ image as luxury service providers.

**Marketing natural therapeutics after the NHS**

The introduction of the National Health Service in 1948 had a profound effect on herbalists. Since their low-income clientele switched to free conventional healthcare, they had to reposition themselves in higher-income markets. This meant greater unity within the therapeutic movement – most herbalists went out of business and only the well-organised service-model practitioners survived.

Herbalists were henceforth offering a luxury service and their public standing improved accordingly. The National Institute of Medical Herbalists (NIMH, as the National Association was called after 1946) did not hide its delight. It was ‘a good thing to see the old type of dusty, squalid herb shop being replaced by smart, modern hygienic premises, free from the questionable claims which have had the effect of besmirching an honourable profession whose aim it is to restore health to the sick’ (Orbell, 1960).

The NHS did not only truncate the herbalists’ patient income distribution. The service mix of surviving herbalists changed as well. Before the Second World War, elite medical herbalists were comparable to general practitioners. Now, the initial diagnosis and treatment were effectually monopolised by conventional medicine and herbal practitioners were more like medical consultants, albeit with a lesser social standing and remuneration. Herbal medicine was in a paradoxical position – neither alternative nor auxiliary. As the National Institute of Medical Herbalists put it:

> With regard to our relations with orthodox practitioners, our principles are so diametrically opposed to orthodox methods that there is little hope – or even desire! – for a close relationship here. We stand proudly by our superior system of medication. At the same time, we have to rely on orthodoxy for help in such things as essential surgery, X-ray and laboratory facilities (NIMH, 1964).

The NHS increased competition between various natural therapies. They had to focus on the same group of customers – the high-income patients who were buying for natural healing because it fulfilled their needs and not because it was the only healing they could afford.

Counterintuitively, a shared customer base also meant a shared interest to improve the image of their industry. After the Second World War, professional associations gradually increased their cooperation. In 1946, the Nature Cure Association of Great Britain and the British Association of Naturopaths merged into the British Naturopathic Association (Dummer and Mahé, 1963, p. 99). The new organisation appeared to be less dogmatic and held a wider perception of what natural healing was. Herbalists were interested in good relations with naturopaths. ‘Fences must be dropped in the field of Natural Therapeutics,’ wrote the NIMH’s organ (Fitness, 1961).

Many points of differentiation had by now disappeared. Herbalists were no longer relying solely on herbs but were paying attention to diet and physical adjustments as well. Naturopaths, in contrast, were paying attention to herbs. Herbalists, Naturopaths, Osteopaths and Chiropractors were called to unite and offer ‘a system of comprehensive natural healing’ (Fitness, 1961).

The second part of the twentieth century saw a growing demand for natural healing. Supply of services increased accordingly. In 1981, a survey found 313 practising herbalists and 220 naturopaths (Fulder and Monro, 1981). By 1997, herbalists had increased their ranks to 1000 and naturopaths to 301 (Mills and Peacock, 1997, p. 57). What these therapists gained in market demand, they lost in fiercer competition. Many attractions of natural therapeutics – the former unique selling propositions – were successfully copied by other competitors. Supermarkets started retailing health foods. Conventional medicine adopted the naturopathic insistence on regular physical exercise and balanced nutrition (Vickers and Zollman, 1999).

Naturopaths reacted by emphasizing osteopathy even more. Accordingly, they renamed the British Naturopathic Association (BNA) to the British Naturopathic and Osteopathic Association (BNOA) in 1961 (Dummer and Mahé, 1963, p. 99, Croft, 1961). At that time, the relations between the naturopathic and the independent osteopaths were still tense (Dummer, 1963). This changed in the late 1980s, when the independent osteopathy resumed its quest for statutory regulation. Naturopaths joined
them and called for registration of osteopathy, too (Journal of Alternative and Complementary Medicine, 1987). In 1988, almost all the 220 members of the BNOA accepted the invitation to join the General Council and Register of Osteopaths (Journal of Alternative and Complementary Medicine, 1988).

Those naturopaths who preferred not to specialise in osteopathy could register with the General Council and Register of Naturopaths. It was originally founded by the British Naturopathic Association in the 1950s but abandoned when the naturopaths focused on osteopathy. Resurrected in 1989, it was overseeing what an industry title called an ‘eclectic, multi-therapy approach to the practice of natural medicine’ (Journal of Alternative and Complementary Medicine, 1989).

In such a conception of naturopathy, dietary advice plays an important role. This field of healthcare, however, has involved legal restrictions. Since the passing of the Professions Supplementary to Medicine Act in 1960, naturopaths could no longer describe themselves as ‘dieticians’. This title became restricted to members of the dietetic profession which had originated, in the early 1920s, on hospital wards, where nurses had specialised in ‘ordering of special diets for certain classes of patients.’ By 1936, they had already formed the British Dietetic Association (Hutchinson, 1961, p. 48). Despite being pushed out of ‘dietetics’, naturopaths could still base their marketing appeals on nutritional expertise. A Register of Nutritional Therapists was established in 1991, followed by the British Association of Nutritional Therapists in 1997 (Mills and Peacock, 1997, p. 34).

Health food shops, too, lost their unique selling proposition. At a time of growing post-war affluence, health foods such as muesli or bran became mainstream and available in regular retail multiples. In 1963, herbalists were already urging their supporters not to abandon health food stores. ‘They pioneered with quality and service,’ reminded the monthly magazine circulated among both NIMH members and customers. ‘Don’t desert the man who offered health foods before Super Markets were heard of’ (Morales and Clark, 1963). There was a sense of vindication in these appeals – supermarkets were not mere competitors, they were a ‘recognition of the coming-of-age of health foods.’

It took few more decades until the age of health foods truly arrived. Up to the late 1980s, health food stores remained sufficiently different from supermarkets and pharmacies. They were still primarily competing among themselves for a minority of buyers – most consumers still regarded them as ‘cranky and overpriced’ (Davies, 1992). The specialist health food sector was growing, though. In 1979, they were an estimated 850 outlets (Hilliam, 1984, p. 2). In 1983, this number already reached 1300. It peaked with 1900 in 1990 (Key Note, 1992). This situation changed in the early 1990s. ‘Robbed of some basis for their product specialization, the health food specialists become victims of their own success,’ wrote a marketing analyst in 1992 (Davies, 1992). They also suffered from the economic recession and their number declined to an estimated 1750 in 1991 (Key Note, 1992, p. 15).

Conclusion
Natural therapists honed their marketing strategies in a long competitive process. In the early twentieth century, there were two main types of complementary practitioners. The first were competing with conventional medicine on price, e.g. the back-street herbalists. Their services were perceived as low-quality substitutes for conventional care. When the British State started to subsidise prices of medical doctors, consumers shifted to them – the introduction of the National Health Service in 1948 made conventional medicine universally accessible and eradicated alternative therapies which had been in direct competition with conventional ones.

The second group of complementary therapists survived the ‘NHS effect’. It consisted of specialists like nature cure practitioners. Their clients had the means to use medical doctors but chose not to. Intermediate groups – the medical herbalists – were forced to specialise in niche needs (to provide natural health in a broader sense) and to cut down on medicinal claims (e.g. medical herbalists no longer claimed to cure appendicitis, and advised patients to seek conventional surgery). By the end of the century, complementary medicine served health-minded consumers but went beyond the simple ‘mending the mind or body,’ or ‘removing disease’. It used appeals loaded with a deeper cultural significance. More precisely, marketing communication was targeted at consumers who associated nature with health and harmony, in line with ancient traditions. The appeals of conventional medicine, in contrast, evoked science and technological progress.

This marketing strategy was tailored to consumer needs that were ancient but remained, until the early twentieth century, largely unsatisfied. Few herbalists sold natural health advice while most
focused on retailing herbs. Supply of services was insufficient in quantity or quality. It presented a business opportunity that was seized by entrepreneurs and innovators – the naturopaths. They introduced new services, recruited new consumers, and faced cut-price competition. Some competitors were imitators while others developed new therapies.

Since the late 1950s and 1960s, complementary medicine was growing in popularity. Cultural explanations cited dissatisfaction with conventional medicine and the New Age movement (Bakx, 1991). They ignored, however, the persisting popularity of complementary medicine among the very rich. With the post-war rise in prosperity, others could afford complementary medicine, too – or had to afford it, since complementary therapists treated some side-effects of affluence. Complementary medicine resembled Janus, the two-faced god of ancient Romans. One face appealed to the rich and provided unique and valuable services. The other was selling to the poor, substituting the basic medical care they could not afford. The latter aspect disappeared with tax-funded healthcare. The former survived and, with the post-war rise in affluence, attracted new customers. The marketing strategy of natural therapists was thus a consequence of two related factors: of niche orientation and of a State-imposed price shift.

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