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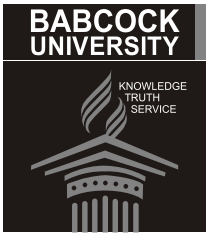

BABCOCK UNIVERSITY
ILISHAN-REMO, OGUN STATE
NIGERIA

THE THIRTEENTH UNIVERSITY
INAUGURAL LECTURE

COST OF BEATING THE BUG: ISSUES IN HEALTH FINANCING

by

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COST OF BEATING THE BUG: ISSUES IN HEALTH FINANCING

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My Lords Spiritual and Temporal, The Royal fathers present,
Special Guests, and friends of Babcock University,
Gentlemen of the press, Distinguished Ladies and Gentlemen

I feel greatly honoured for this unique opportunity to present the 13th Inaugural Lecture of Babcock University, especially as this represents the first of its type in the Department of Business Administration and Marketing.

I have had a checkered career, spanning over a couple of varied vocational disciplines. My first Job after the mandatory National Youth Service Corps (NYSC) service year was in Audit Department at Ilorin in Kwara State in 1976. I moved on from Audit to academics in Kano State Polytechnic, where I rose to the peak position of Chief Lecturer in 1992. Along the line, I taught a few courses in Quantitative Techniques at ABU, Kano campus. I later left for a stint as a Mortgage Bank Managing Director in Lagos. This led me unto another career in Tax and Financial Management Consulting, before I finally retraced my steps back into full time academics again, this time, in Babcock University, and the University of Ilorin.

While I spent my productive career years substantially in academics, my main areas of focus have been in Quantitative Techniques and Financial Management. These areas of

academic interest, coupled with a rather heavy influence of medical practice in my nucleus family have essentially, to a large extent, influenced the choice of the topic for today's Inaugural Lecture.

It is therefore probably unexpected, that I combine my Financial Management conceptualities with the thorough bred Medical infusions of a large number of family members, to come up with a topic in Health Financing in my PhD Thesis at the University of Ilorin in 1996. Hence the topic for this Inaugural Lecture- **"Cost of Beating the Bug - Issues In Health Financing".**

The bug here will generally be representative of the viruses and microbiological elements that cause diseases, beating the Bug will therefore infer, on a larger scale, the preventive and curative measures taken in the medical fight against ill health in humans. And, of course, the financial implications of this medical fight are the cost in consideration.

IN THE BEGINNING

The Bible tells us that, In the beginning, God concluded His act of creation, and looked at all He had created, and EVERY THING was very good. This included man. It also included the health status of Man. Genesis chapter 1, verse 31 reads "Then God saw everything that He had made, and indeed it was very good…." In the beginning, man enjoyed excellent mental, emotional and physical health. It was at the entrance of sin into man and his circumstances that it brought ill health along. How was man to escape the deadliness that sin and its accompanying ill health had brought? It had to be at a cost. A price had to be paid. Isaiah 53 verse 5 indicates that the price of ill health was paid by Jesus Christ. "And by His stripes we are healed". In the physical realm, prevention of diseases and healing of an illness are at a financial cost. This lecture will attempt to describe, illustrate and analyze the various forms, ways and manners in which payment is made for the prevention and cure of diseases especially within the shores of Nigeria. The lecture is a treatise in Health Financing.

INTRODUCTION

There is a common adage that "Health is wealth". This applies to an individual, as much as to a nation. This implies that a great measure and indicator of the wealth of a nation, is the state of health of its citizens, individually and collectively. Empirical evidence has established the concept of a nation's economic development being significantly correlative with the health status of her citizens, who are the essential substance of labour and productivity. (Adebola, 2003). There is also empirical evidence that the format, method and modality by which a country finances its health care delivery system is undoubtedly a key determinant of its citizen's health status. It is Implied, that the choice of an appropriate financing method, and the organizational delivery structure of health care delivery is key to that nation's chance of national goals achievement.

The World Health Organization (WHO, 2000) once defined Health Financing as "Function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system, etc. The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal care (WHO, 2000).

According to WHO (2008), there is a general consensus that the conceptualities of Health financing systems are not confined to the goal of fund raising for health care delivery, but that fund mobilization should be done in such a way that citizens who are end users of health care do not encounter severe financial hardship, or impoverishment, a concept often referred to as financial catastrophe.

Generally, there are five fundamental methods of funding health care delivery, though there are numerous formats for health fund financing that could essentially be subsumed as subsets of one or more of these five fundamental ones. The major methods are general taxation, social health insurance, private health insurance, grants and external aid, and direct out-of-pocket payments by health care end users.

Many developing countries like Nigeria, often experience demographic scenarios in which funding of health care delivery could be substantially influenced by the ratio of economically dependent individuals, the actively productive sector of the population. In such a demographically structured population with more than 45% of the population being less than 15 years old and where the more than 60 years old are more that 30% of the population, these segments of the population could constitute an economic burden on that nation's format of health financing. According to Onotai and Nwankwo (2012), in a WHO study of the effect of health care funding system on the cost of running health care services, equity and access to health care, Nigeria was found to rank in 187th position out of 191 member countries of the World Health Organization. In a multivariate analytical study, Riman and Akpan (2012), it was observed that there was indeed a disproportionate disparity in the spatial distribution of health facilities in Nigeria, besides a high level of infant mortality that was significantly associated with high incidences of out-of-pocket payments for health care, especially in relatively socio-economically impoverished and disadvantaged regions.

A current major worrisome issue in health care financing in Nigeria is the heavily disproportionate skew of sources of funds for the sector. In the opinion of Soyibo (2004), as quoted in Riman and Akpan (2012), the funding of health care in Nigeria has consistently been obviously inadequate. This is due to the national budgetary provision for health care which hardly exceed 3% of total annual national budgetary provisions, which is undoubtedly far less than the 15% recommended by the World Health Organization.

There has, of recent, been a rather large and critical attention on health care financing in Nigeria by health economists. The array of discourse has equally been on a relatively large scale and dimension. According to Riman and Akpan (2012:299), Ichoku (2009) employed the "Aronson - Johnson - Lambert decomposition framework to analyze the redistributive effects of health care financing in terms of vertical and horizontal inequities in Nigeria". In a similar study, also as recorded in

Riman and Akpan (2012), Onwujekwe, Uzochukwu, Onoka, Madubuko and Okoli (2010) examined the effects of out-of-pocket payments on health care outcomes in Nigeria. The studies, like many others, were later considered to be inconclusive, due to their generalization of findings as country-wide applicable, without taking due cognizance of regional demographic and socio-economic variations. In an unpublished study (Adebola, 2015), a rather large variation was found in health care costs in tertiary health care Institutions in different demographic and socio-economic settings. An extract from this study is shown in Table I.

Table I: Financial Costs for Medical Interventions

Medical Intervention	**Cost**	
	BUTH **₦**	**LASUTH** **₦**
Consultation by Consultants	**1,000-2,000**	**Free**
Consultations by other Doctors	**500.00**	**Free**
Bed per night- regular	**500**	**2,100**
Bed per night - VIP	**1,500-2,000**	**4,000**
O&G Charges:		
Delivery pack	**4,000**	**6,500**
Cesarean	**100,000 -120,000**	**68,000**
Normal Delivery	**50,000 - 90,000**	**30,000**
Scan	**2,000**	**3,000**
Blood pack	**3,500**	**4,500**

Note: Babcock University Teaching Hospital Ilisan-Remo: BUTH
Lagos State University Teaching Hospital, Ikeja, Lagos: LASUTH
Source: Adebola (2015)

Mr. Vice-Chancellor Sir, it is important at this juncture to make a clear distinction between financial and economic concepts of cost, especially in the context of this lecture. While financial

costs will usually refer to monetary payments that are directly associated with the purchase of a good or service, economic costs will often relate to a much deeper concept of resource utilization, and the associated opportunity costs. Such economic costs will include skills, time, infrastructure, energy and equipment that may have been employed in the course of the transaction.

In the particular framework for this lecture, economic cost valuations, as they relate to outcomes of health care delivery and financing, are often measured in cost evaluation conceptualities that include the following:

- Cost Minimization
- Cost Utility
- Cost effectiveness
- Cost benefit

Mr. Vice-Chancellor sir, the cost in consideration in this lecture, is the financial cost in health care delivery transactions.

HEALTH CARE DELIVERY SYSTEM IN NIGERIA A STRUCTURAL OVERVIEW

The socio-political system in Nigeria has experienced a large variation, in the past five decades since independence. In a historical perspective, forms and formats of governance have gone through a sizeable number of problems, adjustments and restructures, all aimed at repositioning the nation towards giant development strides as a socio-political entity. In the words of Adebola (2011), "changes of governments at all levels (Federal, State and Local), have been so frequent and haphazard that the resulting dynamics of political instability have neither helped the cause, nor paved the way for meaningful long term plans and projections for socio-economic development. Much of the scheduled development rolling plans have eventually turned out to be a ruse, and can best be described as exercises in futility" (Adebola, 2001:1).

It will be noted that for a rather relatively long period, the administration of health care delivery in Nigeria was structured

in such a way that the local governments were steadily reduced to a relatively dormant posture, only playing to the gallery, in the minimal role they (local governments) were confined to assume, in the primary health care subsector of the national health care delivery system. This was the situation until the tenure of Prof. Olikoye Ransome-Kuti as the Minister of Health. It was during his tenure that the local government health care delivery subsector was pushed into a relatively more defensive posture and encouraged to assume higher proportions in the overall scheme of activities for health care delivery.The health care delivery system can be diagrammatically illustrated by a triangle thus:

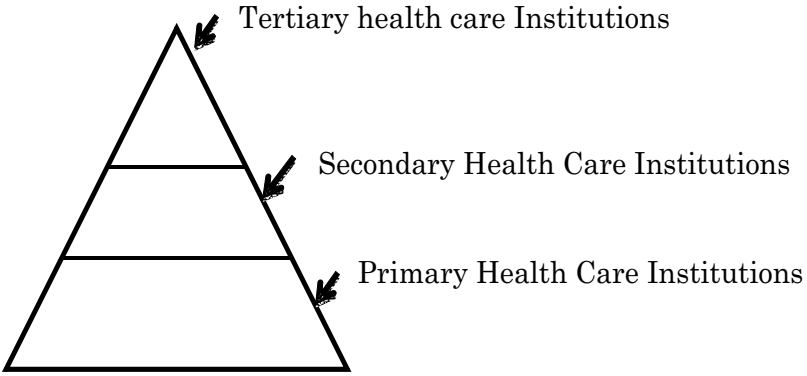


Fig 1: 3-tier Structure of Health Care System.
Source: Author's Concept (2016)

The overall health care delivery restructure is a composite of input, (in the form of personnel, skill, infrastructure, equipment and finance), and outputs, (in the form of healed patients and successful medical preventive measures).

This structure can be further illustrated as in fig 2.

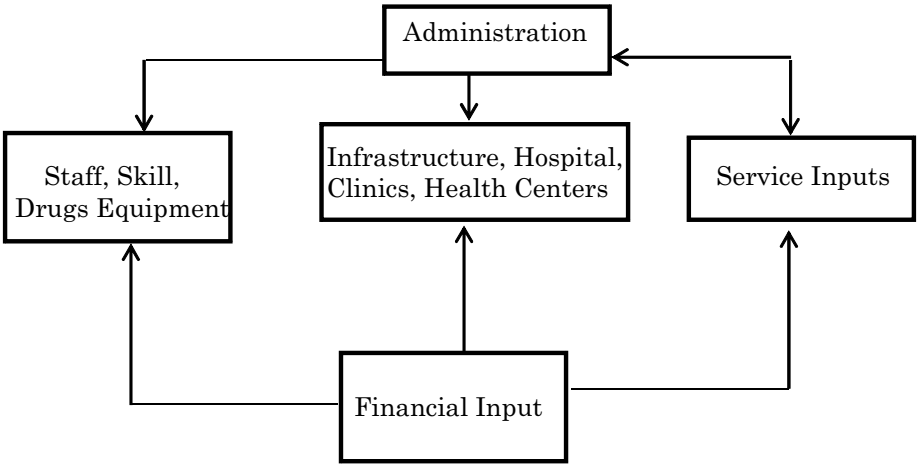


Fig 2. Health Care Structure
Source: Author's Concept (2016)

With the national mixed economy concept, there is ample provision for private health care providers to operate at any of the three tiers of health care delivery structure, i.e primary, secondary or tertiary. Table 2 gives the statistics of registered health care delivery providers as at 2014.

Table 2: Registered Health Care Facilities in Nigeria

	Ownership		
Type	**Public**	**Private**	**Total**
Primary	**21,808**	**8,290**	**30,098**
Secondary	**969**	**3,023**	**3,992**
Tertiary	**74**	**11**	**85**
Total	**22,850**	**11,323**	**34,173**

Source: Fed. Ministry of Health, Dept. of Planning & Statistics (2014)

It is to be noted that, in each of the three tiers of health care delivery system, there are obvious financial costs to be borne by a health care facility or end user. These costs are as illustrated in Fig 3

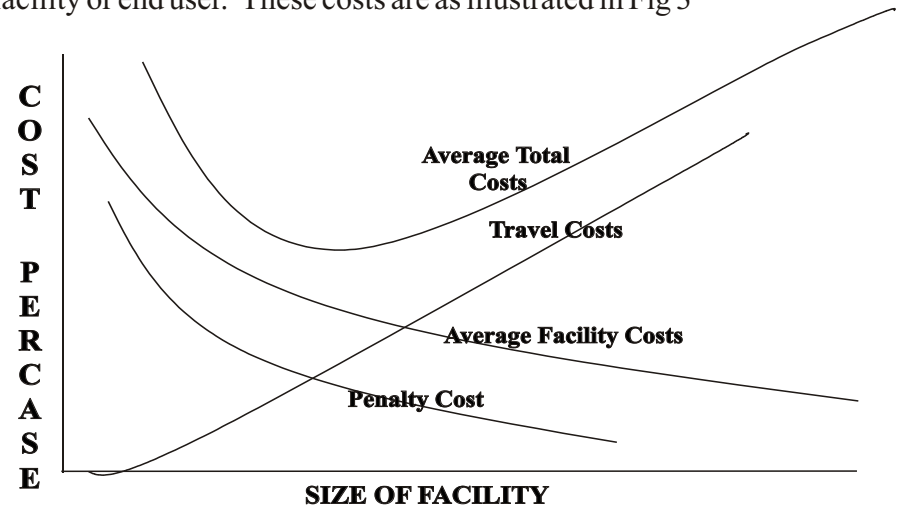


Fig 3: Costs Associated with Health Care Delivery
Source: Adebola (2001:114)

The main thrust of this lecture, is an examination of the different forms and formats of meeting the costs illustrated in fig 3.

PAYING FOR HEALTH CARE A HISTORICAL PERSPECTIVE

Mr. Vice-Chancellor sir, you would recall my earlier statement and position about man's earlier health status at creation as being, not only with a clean bill, but in an actual state of perfection. This would imply logically, that there was no provision made for payment in respect of health care delivery at that point in time. You would also recall, that I further made an assertion that sin brought disease and ill-health to man, but that Jesus Christ actually confirmed that His death on the cross made an atonement for our sins, and that by His stripes, we are healed (Isaiah 53v5).

After the fall of man, in the primordial times, the descendants of Adam had to learn the art of attending to cases

and sessions of ill-health through the application of herbs, leafs and roots. This led to the training of specialized practitioners in the art of health care delivery. Luke, one of the earliest Disciples of Christ, was one of such trained health care personnel.

In a historical perspective, some of the earliest health care practitioners in Nigeria were the traditional healers, the Ifa oracle "Consultants", the Dibia, the Alfa Clerics, and the "Awani", traditional bone setters. These practitioners did not see disease as results of viral or microbial infections, but as results of offenses against the gods who had to be appeased with the use of material and animal sacrifices and incantations. Such materials and animals used for sacrifices were the payments made to the traditional healers for their services.

Subsequently, such payments were made through financial intermediations, initially with payments in cowries, and later in the prevailing currency notes and coins.

Government's attention to health care financing became more robust. Health care systems were later designed to achieve the following for the citizenry in order to:

- Improve the health of the citizens
- Allow for adaptation of health care delivery to needs
- Enhance equity in funding and access to health care.
- Improve health care quality
- Control costs of health care
- Enhance the allocative and technical efficiency of the health care delivery system. ILO (2007).

In the opinion of Ichoku (2011), the achievement of the above stated health care intentions has been programmed along with and precipitated on the required financial provision through the national budget. Unfortunately, the author indicated that health care financing in Nigeria has consistently been characterized by declining national budgetary provisions since 1980. It is on record that budgetary provision for health care plummeted to an abysmally low value, less than 8% of total budget in 1980, giving an average of government health expenditure per capita at about $2, and the average household

health per capita expenditure at $13. These abysmally low levels of government spending on health care have consequently resulted in Nigeria's poor rating among nations. Nigeria's current maternal mortality rate is estimated to be 800per 100,000 live births, infant and under five mortality rate is estimated to be 100 and 201, respectively, per 1000 live births. (Amakom and Ezenekwe, 2012). These health indicators are undoubtedly some of the worst in the world.

Mr. Vice-Chancellor sir, it is on record that in 2011, the Federal Government of Nigeria signed what is often referred to as the Abuja Declaration, which committed Government to spend not less than 15% of the national budget on health care delivery. In spite of this declaration, the Nigerian government in 2013 allocated only 5.6% of its national budget to health care delivery at the national level. The variations in national budgetary allocations to health care at the national level, with the various Heads of Government, are shown in fig 4

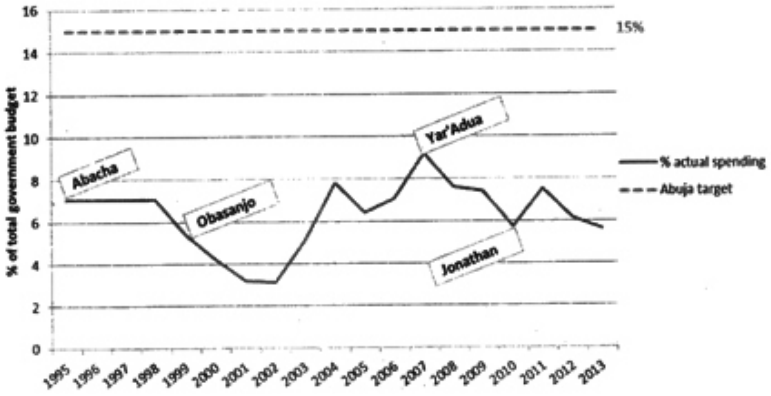


Fig 4: National Budgets on Health care as % of Total Budget
Source: Federal Ministry of finance, Budget office of the Federation, 2013

REFORMS AND CURRENT ISSUES IN HEALTH CARE FINANCING

The methods for financing health care delivery can generally be put into the different broad forms depicted in figure 5.

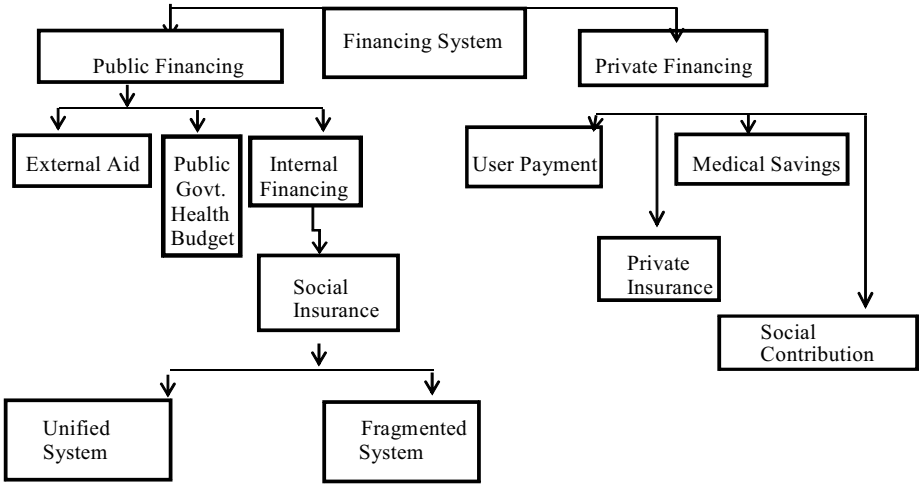
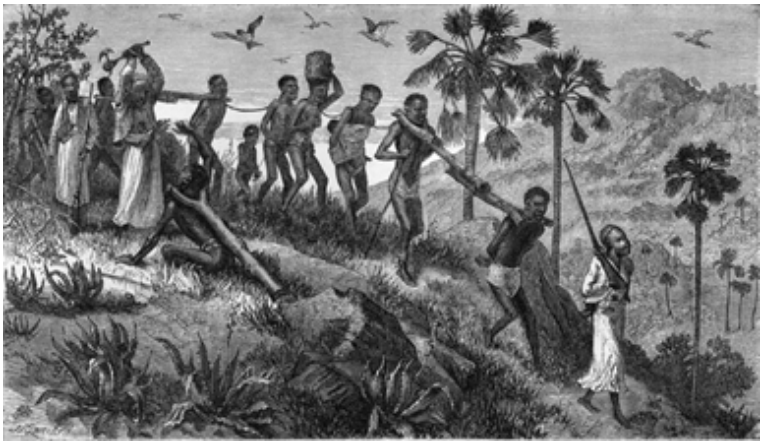


Fig 5: The Different Forms of Health Financing
Source: Adapted from ILO (2007)

Fig 5 above is a diagrammatic illustration of the general methods available globally for financing health care delivery. We shall, at this juncture, proceed to explain, as briefly but as clearly as possible, the adoption of one or more of these aforementioned financing methods by different countries.

DIFFERENT METHODS OF PAYING FOR HEALTH CARE SERVICES

Old Method of Payment



Old Method of Paying for Health Services

Old Method of Paying for Health Services

Old Method of Paying for Health Services

New Method of Paying for Health Services

A. Government Taxation Method

This is a major method of financing health care delivery through the levy of taxation on the citizens by the government; this method is often referred to as the tax-based system for health care funding. The revenue generated by the Nigeria government from general taxation is much lower that the revenue from the petroleum sector. It is from this generally oil-based revenue than the Nigerian government funds its operations, including the health care sector. Since the state and local governments rely substantially on the financial allocations from the federal government, it would imply, by logical extension, that the health care sector expenditures by state and local governments in Nigeria are largely sourced from the national petroleum sector of the economy.

While the federal budgetary component of the national health care expenditure increased from 1.7% in 1991 to 7.2% in 2007, the total federal government expenditure on health care nationally was estimated as 8.69% of Total Health Expenditure (THE) in 2003, 26.40% in 2004, and 26.02% in 2005.

In the opinion of Ichoku and Okoli (2015), most of health indicators in Nigeria are far below the sub-Sahara Africa (SSA) average. The authors also indicated that inspite of Nigeria's position as the SSA second largest economy, with a population estimated at over 160million, and large reserves of oil, life expectancy remains significantly below Africa's average. Table 3 gives data on public health expenditures, in Nigeria and in some other African Countries and the average life expectancies.

Table 3: Nigeria's Health Expenditure and Health Outcomes Relative to other African Countries

Country	Life Exp. (2011) yrs	THE % GDP (2009)	PCH Exp
Algeria	73.1	4.1	191
Benin	56.1	4.2	32
Cameroon	51.6	5.6	61
Egypt	73.2	5.0	112
Ghana	64.2	8.1	53
Kenya	57.1	4.3	33
Liberia	56.8	13.2	29
Morocco	72.2	5.5	156
Niger	54.7	6.1	21
Senegal	59.3	5.7	59
South Africa	52.8	8.5	485
Tanzania	58.2	5.1	25
Uganda	54.1	8.2	43
NIGERIA	51.9	5.8	69
Africa	56.8	5.9	89.4

Source: World Health Statistics (2009)
Note: PCHExp per capita Health Expenditure
THE- Total Health Expenditure
Life Exp Life Expectancy in years

It will be noted from Table 3 that Nigeria had, at the time of data collection, one of the lowest Total Health Expenditure (THE) percentage of GDP, one of the lowest per capita Health Expenditure (H EXP), and by consequential extension, one of the lowest life expectancies. Table 4 gives data on actual Federal Government annual budgetary allocations to health care delivery in a period of about five years.

Table 4: Fed Govt. Budgetary Allocation to Health Care Delivery

Year	Budgetary Allocation (₦' 000)
2005	55,524,410
2007	102,795,110
2008	121,276,200
2009	121,481,590

Source: Ichoku and Okoli (2015)

According to Ichoku *et al*, (2015), evidence from Public Expenditure Review and the National Health account suggests that most states in Nigeria spend, on the average, less than 5% of their total annual budgetary allocation to health care delivery. Evidence also suggests that, since many households cannot afford direct payment for health care in the face of dwindling allocation to the sector by all 3 tiers of government, such households either suppress their health care needs by not reporting for medical intervention when they fall ill, or they resort to self -medication and patronage of quack and unqualified medical practitioners. Empirical evidence (Ichoku and Okoli 2015), there is suggest that a country's per capita expenditure on health is significantly and positively correlated with that country's GDP.

b. Out-of Pocket Payment

This is a health care delivery financial system in which direct monetary payments are made by health care consumers for services received at the point of service. The charges levied at the point of health care series are often referred to as user fees. These fees will often refer to a combination of charges that include payment for drugs, cards, consultation, overnight bed occupancy, medical material costs and surgical interventions.

The out-of-pocket medical fee was largely introduced at the federal level of health care delivery in Nigeria in 1988, following the Bamako Initiative which advocated community and end user cost sharing participation in health care delivery. The underpinning logic that pushed the Bamako Initiative was that cost sharing was likely to eliminate waste, and also increase equity and efficiency in medical resource utilization. The intellectual baloon of this argument was, however, punctured by Ogunbekan, Adeniyi, Wouters and Morrow (1998), when they argued that user-fees actually resulted in declining utilization of health care service, due to the alarming level of poverty among potential users of such services. In a Technical Report, (Soyibo, 2002), Out-of-Pocket proportion of THE in Nigeria was an average of 64.59% between 1998 and 2002, while it accounted for 74% in 2003, 66% in 2004 and 68% in 2005. It is evident from these figures, that households generally bear the greatest bulk of health care expenses. This will generally imply a deep bite into what would have been available to households in meeting other financial needs or for economic investment. In other words, out-of-pocket health expenditure generally has a significant displacement effect on household budgets.

When household health care expenditure exceeds 40% of their total income, such health care expenditures are often referred to as being catastrophic. The Nigeria National Living Standard Survey of 2004 reported that due to the persistent poor levels of government expenditure on health care, out-of-pocket expenditure in Nigeria averaged about $22.5 per capita, while about 7.9% of Nigerians had catastrophic healthcare expenditures between 1995 and 2004.

In an attempt to enhance the earlier achievements of the Millennium Development Goals of 2015, the federal Government of Nigeria, as a means to achieving its 2020 vision, has resolved to enhance public expenditure on health care. This renewed impetus is aimed at achieving the following health targets:-

- Improve Nigeria's ranking in the Human Development Index(HDI) from the rank of 157 (out of 177 countries) to 80.

- Reduce maternal mortality which stood at 545/100,000 live births by about 75%.

- Reduction of under-5 mortality from 189 per 1000 to 75 in 2015 and 50 in 2020.

- Increase in life expectancy to 70 years by 2020 (Nigerian Demographic Health Survey, 2008).

A Socio-political and demographic survey of the distribution of cases of out-of-pocket payments for health care in Nigeria, and reported in 2008, gave the data in Tables 4 and 5 as reported in Osungbade *et al* (2012).

Table 5: Mean Distribution of Out-of- Pocket Health Care Expenditure by Geo- Political Zone in Nigeria Per Annum

Geo-Political Zone	**Mean / Out-of-Pocket Health Expenditure PA (₦)**
North Central	22,024.01
North East	25,027.57
North West	27,813.04
South East	56,381.24
South South	41,230.02
South West	22,392.70

Table 5 above indicates clearly that while residents in South-South and South-East geo-political Zones of Nigeria have to contend with the highest user fee payments for medical care, the residents in North central and South West Zones pay the least

out-of-pocket equity portions in health care delivery financing. The latter could be consequent upon the free medical care of the post-colonial Obafemi Awolowo regime, and the Socio-Political Welfarism ideology that successive governments in those zones have tended to imbibe.

Table 6: Mean Distribution of Out-of- Pocket Health Care Expenditure by Demographic Segmentation

Sector	Mean / Health Expenditure PA (₦)
Urban	**29,223.22**
Rural	**32,047.58**

Table 6 indicates a significant disparity between average household health expenditures in urban and rural regions of the country, with the rural dweller having to be more saddled with user fee payments for health care. This puts the rural dwellerat a greater disadvantage than his urban region counterpart, largely because the rural dweller's average income is lower than that of the urban dweller. Osungbade, Olanrewaju, and Olyiwola (2012) estimated a household's payment for health care, besides other non-food items thus:-

$$Zj = \frac{Hexp}{NFexp} \times 100$$

Where Zj = share of health expenditure in non-food expenditure
Hexp = average household monthly expenditure on health care

NFexp = average household monthly expenditure on non- food items.

There have been calls for the exemption of the Socio-economically poor from the user-fee mode of payment for health care. Unfortunately, in the opinion of Onwujekwe *et al* (2010), like many other academics, attempts to exempt the poor from

outof-pocket payments could be fraught with many logical, and technical problems. One of such major problems is the proper and objective identification of the actually eligible poor. This could raise a moral, technical and financial burden on the system.

c. Social Health Insurance

This is a health care payment format through an insurance scheme into which health care consumers are expected to contribute a regular and periodic financial premium, in anticipation of eventual needs for medical interventions. The insurance scheme operates within a well defined framework for health care end users and providers.

A health care insurance scheme was established by the Nigerian Government in 1999. The scheme was brought into formal legal existence via the Act 35 of 1999. Known as the National Health Insurance Scheme (NHIS), the service became fully operational in 2005. The scheme, designed to ease the burden of payment for health care need through funds provided from various contributors, usually on a national scale, with employees and employers of labour contributing a specified percentage of emoluments as insurance premiums. The programme is segmented into a number of functional Social Health Insurance Programme (SHIPs) that include the following: Urban self-employed, Rural Community, Formal Sector, Permanently Disabled persons, Prison Inmates, Children under five, Tertiary Institutions, Armed Forces, Police and other uniformed services, and Voluntary Participants. As at date, in the year 2016 only the formal sector of the SHIPs has become fully operational. The operation of the NHIS is expected to be in harmonized liaison with accredited Health Management Organizations (HMOs).

D. Community Based Health Insurance

This is a type of Health Insurance Scheme that involves an organized cooperation of individuals for families or community

groups coming together to co-finance the costs of health care delivery. This scheme is usually designed for moral dwellers and those in the informal employers sector. While the National Health Insurance scheme is mandatory for certain sectors of the economy, the Community Based Health Insurance is usually voluntary. In an unpublished study (Adebola and Afolayan, 2014) while residents in Shagamu and largely participants in the Ikenne Local governments of Ogun State were aware of NHIS scheme, majority of members of this study feined complete ignorance of the Community Based Health Insurance. This format is often referred to as the "Market System". Here, in the words of Onotai and Nwankwo (2012)"Private provision predominates"

e. Donor Funding for Health Care

This refers to the Grants-in-Aid and financial assistance often rendered for health care delivery in developing countries, by donor countries and organizations. The average annual health care financial aid to Nigeria in 1999 and 2007 was estimated to be $2.335 and $4.674 per capita respectively (Olakunle, 2012). These figures are a far cry from the actual Nigerian Health financing needs and very much below the average sub-saharan African figure of $28 per capita. According to Adebola (2007), the major challenges with donor funding in Nigerian health care delivery will include corrupt practices, mismanagement and fraudulent diversion of such aids, and ineffective coordination of the funds utilization. The misuse of donor funds, just like the misapplication of government budgetary allocations to health care delivery, have rendered almost ineffective the ultimate expected desired health status of the citizens. This was encapsulated in the words of Adebola (2000:62) thus: "Budgetary pronouncements, and financial allocations for health care delivery are only matters of government fiscal monetary policies, what actually translate into health care are the productivity level and efficiency of the health care delivery system". In the opinion of Adebola (2007), such misappropriation of financial allocations to health care either through government allocations

or donor funds, has virtually eroded the life expectancy (LE) of the citizens. In an empirical study of the Lagos State health care, Adebola (2007), generated the model equation:

$LE = \alpha_1 TM + \alpha_2 EVM + \alpha_3 DT + \alpha_4 SOV + \alpha_5 FD + \alpha_6 ABF + \alpha_7 ABJ + \alpha_8 UQS + \beta$ Where TM, EVM, DT, SOV, FD, ABF, ABJ and UQS are defined forms of systemic corruption and β is the stochastic value. The study concluded that, while the Durbin Watson result resonates the model equation homoscedasticity potential, the robustness of the model's ability to predict accurately the impact of Corruption on Life Expectancy is not in doubt.

d. Debt Relief Health Financing

This is another form of Health Care financing, in which debt reliefs are granted to Heavily Indebted Poor Countries (HIPC) with a strict proviso threat the monetary quantum value of such reliefs should be exclusively expended on health care funding for the indebted countries concerned. It was in this wise that when Nigeria was also to negotiate a debt overhang of about $18 billion in 2003, there was a government policy commitment to convert the debt relief savings for Socio-economic development, including health care delivery. It would be recalled that the Nigerian government service payment to GDP ratio of 1.2% in 1981 to 5.1% in 1984, 11.8% in 1990 and later dropped drastically to 0.9% at the tail end of the Abdulsalami military government in 1998. This Debt Service Payment to GDP ratio steadily increased to 25.9% in 2002 and eventually peaked at 32.5% in 2003. It was at this time that the idea of a national request for debt relief was mooted. The reliefs granted eventually turned out to be a saving grace for funding the health care delivery system. (Adebola, 2004).

VARIATIONS IN HEALTH CARE FINANCE UTILIZATION EFFICIENCY

(a) By Demographic Segmentation

There has been some controversy among scholars about the actual definition of the concepts of demographically "urban" or "rural" areas. Anderson (1971) and Gutkind (1974), as quoted in

Adebola and Adefila (2004), are such scholars. Authors like Kemijika (1970), as quoted in Adebola and Adefila (2004), did actually postulate that urban and rural communities do not exist of themselves in a vacuum, but that the principal and fundamental characteristics of one group may be found actually shading into and blending with the other group. In the opinion of these scholars, a scale, rather than an outright distinctive dichotomy, might better provide the most satisfactory devise and measure for a more realistic classification of a population setting, and its description as either rural or urban. In fact, Smith (1951) Redfied and Singer (1955) actually referred to urban and rural settings as a continuum.

However, this lecture is not about the academic definition or delineation of what will constitute an urban or a rural setting. What is of concern to us here is that, with the ordinary and generally acceptable definition of the urban or rural community, we wish to examine the possibility of a differential between the efficiency of the use of financial resource in health care delivery in these apparently demographically different human settings.

Mr. Vice-Chancellor sir, there has been a raging controversy among Health Economists and Medical Practitioners, on the critical issues of resource usage efficiency in the hospital environment. While Health Economists often aspire towards an efficient use of resource, where all wastes are eliminated, the general medical practitioner will often see it from the view point that human life cannot be quantified in monetary terms, and that the end justifies the means. This will imply that as long as the sick regains his health, no resource utilization can be considered a waste.

McGuire (1987) was of the opinion that hospitals are technically inefficient, because they exhibit positive transaction costs, and give rise to a system of property right that is somewhat often atypical and therefore the health care delivery system is most unlikely to ever attain the frontier of utilization efficiency. However, Wagstaff (1989) actually found the position

and line of argument of McGuire rather curious, extreme and pessimistic. In the words of Adebola and Adefila (2004:22), "Wagstaff opined that technical inefficiency is not an inbuilt feature of the hospital sector, and that such inefficiency, (or otherwise), of the hospital and production process varies even among hospitals operating in broadly similar environments" Mills (1990) tended to maintain a position of non-commitment and neutrality, when he opined that due to the fact that cost accounting studies can only generate single point estimate of unit costs, and because of the difficulty in obtaining a sample of hospitals that are comparable in terms of quality, service delivery, and structure of case mix, such studies are usually unable to draw firm conclusions on costs efficiency of health care financing.

This lecture may find Mills position not very acceptable, as the various factors that stimulate and aggregate differentials in various health care delivery units are actually the very reasons to which cost efficiency differentials are attributable.

What we have observed, is that differences in such factors as hospital size, service delivery sophistication, case mix structure, and bed occupancy rates actually do create consequential imbalances in cost efficiency of resource usage on the health care delivery system. In their study of urban and rural demographic regions of Lagos State, taking data of Case mix in the department of surgery and obstetrics and Gynecology, between 1996 and 2002, and using an adaptation of the Diagnostic Related Group Cost Utility Cohen technique for the measurement of Efficiency Ratio, Adebola and Adefila (2004) actually found that geo-demographic differentials could impact significantly on the efficiency of resource usage in the health care delivery system. Indeed, Adebola and Adefila (2004) using the Reconstructed Cohort method, were able to draw sustainable inferences that health care units in geo-demographically rural areas tended to approach the frontier of higher financial resource efficiency than the ones in the urban regions. This is largely in agreement with the position of

Olaniyan and Lawanson (2010), who observed that despite the severe budgetary constraints and uneven distribution of resources among the urban and rural areas, with the rural areas mostly affected by unequitable budgetary health expenditure allocation, a higher technically more efficient resource usage is noticed in the urban areas.

(b) By Socio-Economic Segmentation

The concept of poverty has engaged academics and notable scholars in raging debates over the centuries. Who is actually the poor man? Is it the materialistic opulent who has poverty of ideas of how to spend his money, and who has no rest of mind? Or is it the man with lean material resources, but who is prudent and endowed with divine Godly wisdom? The Holy Bible describes the widow who gave all she had to divine cause, and therefore rich towards heaven, much richer that the opulent who gave a portion of their wealth and remained rich only in earthly discretions.

A World Bank Poverty Assessment Report described the incidence of poverty as "The proportion of the population whose consumption is below the poverty line" (World Bank 1473, 1996). The Food and Agriculture Organization (FAO) described a poverty line as "The monetary amount that would provide a basket of commodities that will allow the consumption of food products containing 2,100 calories per person per day (World Bank, 14733, 1996).

In the opinion of Adebola (2000), the discovery of crude oil in Nigeria actually afflicted the national economy with the "Dutch Disease". This, according to Adebola (2000:81), is "an economic phenomenon in which a sharp increase in the output of and reversal from one product in an economy has adverse repercussions in other sectors of the economy. This situation is most pernicious and precarious when the revenue from that product that gave rise to the problem reverses itself, and the economy is left high and dry with an inappropriate output composition". This situation often leads to what is often

referred to as the "Real Effective Exchange Rate". The effects of the Dutch Disease in Nigeria could not have been more pronounced than now. The sudden rise of the national income from the oil sector, and the subsequent neglect of agriculture and other sectors of the economy, has led us to where we are now in the year of our Lord 2016, when exchange rate has changed from 1 US dollar per sixty kobo, and 1 pound sterling per one naira twenty kobo in 1980 to 1 US dollar per four hundred naira and 1 pound sterling per five hundred and twenty naira in 2016 respectively. The economy has gone so bad that the Lagos-London route that I used to fly for Five Hundred Naira (N500) in 1980 now in 2016 costs Four Hundred Thousand Naira (N400, 000) this, is the Real Effective Exchange Rate. The situation has become similar to what, in the opinion of Tella (2014), can be succinctly described as a completed and tactical move away from "The prediction of Thomas Mathus, that growth in production may not be able to catch up with population growth such that incidences of poverty could become the order of the day".

Our major concern here in this lecture is not about the Economist's Real Effective Exchange Rate, but how socio-economic segmentations of poverty and wealth can impact on the efficiency of health financial resource utilization. In the opinion of Sandefur (1983), the perspective model offers the most suitable model for the evaluation of an organizational efficiency. This requires a clear definition of the interest group, the criteria for evaluation, and the cost and benefits from the perspective in view. From the view point of Egwakwe, Adebola and Audu (2009), the commonly used perspective for poverty evaluation has become dysfunctional as it ostensibly emphasizes the materialistic dimension. In the words of Egwakwe, Adebola and Audu (2009), "the relative precept which is a progenitor of the limitations of absolute view lacks universal acceptance". Thus this endeavor captures elements of both definitions towards conceptualizing the commonly cascaded poverty through intractable and accommodative behaviours in communities". This is the perspective, from which we shall see

the concept of poverty in this lecture. In quantifying the efficiency ratio of resource utilization in socio-economically rich and poor regions, Adebola (2000) utilized an adaptation of the Weighted Output Rate, as identified and used in Adebola (1986), to arrive at comparative values of efficiency rate of financial resource utilization in socio-economically different regions of Lagos State. The conclusions drawn from the study were clearly indicative of a significant difference between the two values. And taking into consideration the presumption and notion that the hospital production process is by nature inherently stochastic, it became evidently conclusive that socio-economically poor regions recorded higher values of resource utilization efficiency than the richer regions.

I wish to make it abundantly clear at this juncture, that medical interventions being considered in this lecture and report, do not include such erratic and bizarre interventions as medical Euthanasia, that is the system of "assisted killing. We remember a recent case of one Mrs. Gill, aged 75 years, who suffered from a debilitating illness that was not considered life-threatening. Mrs. Gill however, thought she had had enough of the pains and decided to seek assisted or "mercy" killing, a medical term, also called Euthanasia, which implies assisted life-termination that will not be considered suicidal, and therefore, in legal terms, not criminal, but perfectly lawful.

Mrs. Gills travelled to Switzerland, together with her husband and son, who were willing to respect her wish. Having completed the required documentations, and paid the medical out-of-pocket fees on the 3rd of August 2015, Mrs. Gill was assisted using a fatal injection and put to death in Switzerland. Such use of medical intervention is considered a waste and ungodly, and does not in any way come near the health care medical interventions within the purview of this lecture. In the opinion of Adebola (2008), public expenditure on health care delivery in Nigeria is less than $5 per capita, as against the internationally WHO recommended rate of $15. Such scarce resource can hardly be expended on apparently wasteful and

obviously ungodly and bizarre medical practices such as Euthanasia, the act of mercy killing.

AN ANALYSIS OF REFORMS IN HEALTH CARE FINANCING

a) Major Issues and Concepts

It is on record that health care spending has grown globally by an average of 2.7% faster than any other item of consumption in the economy in the past three (3) decades. (Fuchs, 2009). Attempts have also been made by many governments and nations to, not only achieve a significant move in cost shifting, but also in cost reduction in health care delivery.

The Nigerians health care delivery system has not been left out in the global race at reforms in health financing. Another angle to the reforms is the creation of a distinction between allocative efficiency in health care financing (i.e. doing the right thing) and technical efficiency, (i.e. doing it the right way), in the use of health care resources. (Mclntyre, 2007).

In the word of Akinkugbe, Chama Chiliba and Tlotlego (2012:367), A health system is fairly financed if the ratio of total health system contribution of each household through all payment mechanisms to that household's capacity to pay (effective non-subsistence income) is identical for all households, independent of the households health status or use of the health system.

It is on record that a major reform in the Nigerian health care funding began with the enactment of Act 35 of 1999, which sought to establish the Nigerian National Health Insurance Scheme (NHIS), which tended to combine the principles of socialism with the actuarial scientific techniques and mechanisms of productive insurance. By this scheme, the health care needs of contributions are met financially from a centralized pool of funds from all participants in the scheme.

It will be noted historically, that a bill for a National Health Insurance was first introduced to the Nigerian parliament in 1962, but it was not approved. This was followed by a

commissioned study of the subject in 1984, which resulted in the formal acceptance and launching of the scheme in 1997, with the enabling law, the Act 35 of 1999 coning into existence. The reformation efforts were heightened in 2003, when the Federal Government carried out another restructure of the National Health Care Delivery System, in the context of the National Economic Empowerment and Development Strategy of 2003 2007.

The NHIS has undoubtedly grown massively from inception, to the current coverage of the population projected at about 42%. (Omotai and Nwankwo, 2012). According to Afolayan Oloye (2008), the NHIS was designed to operate through two functional levels

(i) **Regulators:** These include the NHIS Council, the Inspectorate, State NHIS Boards, Licensing Board, the Standards Committee and the Arbitration Tribunal.

(ii) **Delivery Media:** These are the registered Health Maintenance Organizations.

b) **Achievements and Advantages**

The National Health Insurance Scheme has received a major boost from the Drug Revolving Fund Initiative, especially towards effective health care delivery by the Primary Health Care Operators. The Federal Government also further energized the scheme with the introduction of the Petroleum Trust Fund in 1997.

A WHO (2000) report presented the ranking of health system performances by countries in that effort at enhancing good health care coverage at equitable and affordable costs. This report has placed Nigeria in the 187th position out of 191 countries. This is still a far cry from the desired national position, especially when compared to the 175th position of South Africa, the 37th position of USA, the 18th position of UK, and the pinnacle 1st position of France, (Murray and Frank, 2000). The NHIS has undoubtedly enhanced a wider access to health care

than would normally have been the case without the scheme. It has also helped to reduce the financial burden for health care from the shoulders of government. Due to the enhancement of health care delivery performance through the NHIS implementation, the overall health care system at the national level has been able to attract more attention and assistance by international donors and agencies.

c) Disadvantages and Value Loss

A general disadvantage of the Health Insurance Scheme is the tendency to overload this system through somewhat and sometimes unnecessary utilization. Patients hospitalization for cases that can be treated on out-patient basis could lead to overutilization of the system. (Fuchs, Emmanuel, and Garber, 2007).

In the opinion of Fuchs and Emmanuel (2008), health facility overutilization can come in two forms, higher volumes of hospital visit and overload of tests/drugs prescription. Either of these forms can lead to wasteful usage and eventual undesirable reduction in utilization efficiency of health financial resources.

Due to inequitable premium contributions, the socio-economically poor are often pushed to relatively disadvantaged positions in coverage of disease type by the NHIS. It is also noted that a poor management of the NHIS can lead to heightening of health care costs and eventual loss of value.

A COMPARATIVE OVERVIEW OF HEALTH CARE FINANCING GLOBALLY

While government taxation funding for health care delivery is the most common method for health care financing globally, there are variations among different countries in the other health financing techniques employed. Accompanying these various financing methods are the various health care performances achieved. The generally applied system for health financing in Rwanda is the "Performance-based" System. This

system has received considerable support from the international donor community, (Noltre*, et al*, 2014). The United Kingdom operates a very effective National Health Service, which is funded mainly through general taxation, often referred to as the Beveridge System. The Scheme, according to Savedoff (2004), operates essentially like a Public Insurance System.

France operates a well-organized Social Health Insurance often referred to the "Bismarakion System". The system was first introduced in Germany in 1883 by a man called Bismarak. It is a variant of the Private Insurance health Scheme. The Private Insurance Health Financing Scheme is a significant format for health care financing in the USA. It is often called the "Market System". According to Walshe and Smith (2006), the Market System is predominantly dominated by the involvement of the public in its funding and system regulation. India operates various health financing Insurance Schemes that are in the following categories: Mandatory, Voluntary, Employer-based and NGO-based. Table 5 below gives some data, on a comparative basis, of the health expenditure statistics of some countries in Asia.

Table 7: Health Care Expenditure in Some Asian Countries

Country	GDP per Capita 1990 (US $)	Public Expenditure as % of Total HE
Bangladesh	204	43.8
China	311	60.0
India	353	21.7
Pakistan	354	52.9
Indonesia	596	35.0
Thailand	1,558	22.0
Singapore	13,658	57.9

Source: Pradhan, (2012)

RECOMMENDATIONS

Mr. Vice-Chancellor Sir, having gone through the above treatise, especially on the formats for financing health care delivery, not only in Nigeria but also on the global dimension, I make bold to recommend the following:

1. A massive nationwide campaign should be embarked upon to sensitize the generality of the Nigerian population towards the advantages of the National Health Insurance Scheme. This will be with a view to broadening and enhancing the NHIS base, for more corporate inclusions and involvement of the formal sector of the economy.

2. Efforts should be made by government, corporate bodies and non-governmental organizations to initiate and establish community Health Insurance Schemes. This will enable the informal sector, especially in the rural areas, to take due advantage of the benefits that accrue from participation in Health Insurance Schemes.

3. Tax revenue from specific items of consumption, such as tobacco and alcohol should be channeled towards strengthening health care at the primary level. This will help to reduce undue pressure at the secondary and tertiary health care levels, and also go a long way to reduce the cost of providing health care services at the secondary and tertiary levels.

4. The Federal Government should strive harder at increasing the annual budgetary allocations to health care delivery. Efforts should be made to approach, if not even exceed the internationally recommended 15% benchmark of annual budget.

5. The health of a nation's citizenry ultimately determines the national state of wealth. It is suggested that a certain percentage of annual profits declared by all registered

corporate bodies operating in the country should be harvested and dedicated to development in the health care delivery system in the country. This will be similar to the Education Trust Fund currently being practiced.

6. There should be a considerate reduction in the custom tariffs being levied on imported drugs and medical equipment.

7. Governments at all levels and tiers in the country should make special budgetary provisions for the training of medical personnel at specialist levels. This could come in the form of scholarship, bursary or educational loans. This will enhance capacity building for health care delivery, and ultimately reduce the colossal amount being spent on seeking health care outside the country.

8. Special allowances, in the form of living conditions and emoluments should be provided to attract medical personnel to practice in rural areas. Travel costs to urban located medical facilities will be reduced. This will reduce the high cost of health care, relative to income, in the rural areas.

9. The National Primary Health Care Development Fund should be properly funded through dedicated revenue raised at source from federal allocations to state and local governments. This will be used to enhance health care delivery at the primary level, and enable easy access at cheap financial cost by a larger population.

10. Mr. Vice-Chancellor Sir, we are told that charity begins at home. I believe that the cost of medical care at the Babcock University Teaching Hospital (BUTH) could be reviewed downward for a significant section of the university community, especially for daily rated staff and fixed sum staff on the university payroll. I will suggest, in the interest of equity and biblical spirit of being our brothers' keeper that

a restructured premium cost sharing formula be put in place to ease the burden of health care expenditure for this category of relatively low income workers of Babcock University.

MY CONTRIBUTIONS TO SERVICE IN THE COMMUNITY OF UNIVERSITIES

Mr. Vice-Chancellor Sir, I give thanks and glory to Almighty God, who has granted me the breath of life, and the opportunities to serve in various capacities in the university system, and other tertiary educational institution system within and outside Nigeria. These include, but not limited to the following:

a. SERVICE OUTSIDE BABCOCK UNIVERSITY

1. Supervisor for doctoral students at Leeds Metropolitan University, United Kingdom 2011 till date
2. Assessor for Professorial candidates, University of Ghana Business School 2016.
3. External Examiner, Katsina State Polytechnic, 1980-1990.
4. External Examiner, Kaduna Polytechnic, 1984 -1988.
5. External Examiner, The Polytechnic, Ibadan, 2006 -2008.
6. External Examiner, Tai Solarin University of Education, Ijagun, 2009 till date.
7. External Examiner, University of Ilorin, Ilorin, 2009 till date.
8. External Examiner, Covenant University, Otta, 2008 till date.
9. External Examiner, Olabisi Onabanjo University, Ago-Iwoye, 2010 -2014.
10. External Examiner, Lead City University, Ibadan, 2010 till date.
11. External Examiner, Afe Babalola University, Ado-Ekiti, 2012 -2014.

12. External Examiner, McPherson University, Sotayo, Ibadan, 2015 till date.
13. External Examiner, Redeemers University, Ede, 2014 till date.
14. External Assessor for professorial candidates, Obafemi Awolowo University, Ile-Ife, 2013 2014.
15. External Assessor for professorial candidates, Lagos Business School, Lagos, 2016.
16. External Examiner, Obafemi Awolowo University, Ile-Ife, 2014 till date.
17. External Assessor for professorial candidates, Lagos State University, Ojo, Lagos, 2012.
18. External Assessor for Afe Babalola University, Ado-Ekiti, 2012 2014.
19. Dean, Faculty of Business & Social Sciences, Adeleke University, Ede (Sabbatical Leave), 2013 2014.

b. SERVICES WITHIN BABCOCK UNIVERSITY

1. Chair, Committee for Identification and Labeling of Offices, Classrooms, and Lecture Theatres in BU (2004).
2. Timetable/Examination Officer, Department of Business Administration and Marketing (2002).
3. Head, Department of Business Administration and Marketing (2003 2008).
4. Chair, Committee of Heads of Departments, Babcock University (2004).
5. Member of Senate (2003 2016).
6. Nominated as an International Attendee at the NAFSA 2012 Annual International Educators Conference in Houston, Texas, USA (May 27 June 1, 2012).
7. Dean, Faculty of Management and Social Sciences, (later became SMSS, and then later BBS), (2009 2013).
8. Member of Babcock University Governing Council, representing Senate (2000 2015).
9. Member of Ways and Means Committee (WAMCOM) (2008 2015).

10. Member, Academic Standards Board (2009 2016).
11. Member, Curriculum Committee (2009 2013).
12. Member, Colloquium Planning Committee (2010 2013).
13. Member, Postgraduate School Board, (2010 2016).
14. Chairman, E-learning Curriculum Committee (2013 2016).
15. Academic Adviser, SIFE, (name later became ENACTUS) (2009 2016).
16. Director, Babcock Centre for Executive Development (2015 2016).
17. Member, BU Developments Committee (2010 2013).
18. Chairman, Projects Committee for Babcock Industries Group (2015 2016).
19. Chairman, Babcock University Committee on Private Projects participation Policy (2015 2016).
20. Member, BABCOOP Administrative Committee (2010 2016).
21. Chair, Investigation Panel on Adventist Health Study (2016).
22. Member, (and later Chairman) Panel on Investigation into BABCOOP Finance Activities (2012).
23. Member, Planning Committee for Babcock Journal of Management of Social Sciences (BJMASS) (2003).
24. Associate Editor, (later Editor-In-Chief) for BJMASS.
25. Chair, Babcock University Staff Audit (2012).
26. Member, Babcock University Appointments and Promotions Committee (2008 2016).
27. It is on record that within the academic community both locally and internationally, I have singularly supervised 17 Ph.D Theses and co-supervised 9 Ph.D Theses. I have also singularly supervised 24 M.Sc Projects

CONCLUSION

Mr. Vice-Chancellor Sir, I hope I haven't bored you with this rather lengthy treatise. Someone once defined medical care as "A system that helps to kill your illness with its pills; and later

helps to kill you with its bills". This lecture has attempted to help us agree substantially with the first part of the definition, and to disagree completely with the second part. With the right choice of health care financing mechanism, the cost of beating the bugs should not in any way kill the sick. The concern of this lecture is substantially how to mobilize and utilize financial resources optimally for health care. An African proverb says that "a hunter who has only one arrow does not shoot with a careless aim". Financial resources are scarce, and therefore every care must be taken in their use, even for health care delivery.

I am reminded of a statement by Socrates- "The secret of change is to focus all of our energy, not on fighting the old, but on building the new". I hasten to mention that I am not in any way referring to the political parties PDP, or APC here, neither am I making the slightest reference to the political juggernauts and heavy weights, men and women, of timber and caliber, who decide what, where, when, and how we pay for health care in Nigeria. I am not even thinking of Mohammed Buhari and his co travellers in the "Change" vehicle.

What I am thinking, and talking about is the needed change in the way health care delivery is financed in Nigeria. The change I am thinking of is the one that will enable every man, every woman, every adult, every child, every professor, every cleaner, every teacher, every office assistant, every pastor, every vice-chancellor, every registrar, every driver, every gardener, every administrator, every medical officer, every accountant, everybody who still has breath in him, on this side of heaven, to have easy and affordable access to health care service.

Until then, there is one healer that I know who is ever accessible, and is always affordable, the Lord Jesus Christ, who has consistently reminded us in Isaiah Chapter 53, verse 5:

> "*But He was wounded for our transgressions, He was bruised for our iniquities, the chastisement for our peace was upon Him, and BY HIS STRIPES, WE ARE HEALED*".

Mr. Vice-Chancellor Sir, that is my humble submission, I must thank you a great deal for your attention.

ACKNOWLEDGMENTS

Mr. Vice-Chancellor, Sir, where do I start from? I have come across various and many individuals, groups, societies, and personalities, both secular and spiritual, who have meant so many things in my journey of life, that I don't really know how I can ever thank them enough.

I must first give thanks and praises to the Almighty God, for His continuous care, provisions, love, mercy and enablement for all the activities in my life, that have led me to this day. To Him be all the glory.

I remember my root and foundation in life, my late parents, Pa Benjamin Adebola (AKA Honorable) and Madam Esther Abiola Adebola, both of blessed memory, who sowed the seed of commitment and hard work in me, which has undoubtedly germinated and blossomed into the modest achievements the good Lord has allowed to come my way in life. I must be equally thankful to members of my immediate and nucleus family, to whom I owe tremendous gratitude. Special thanks go to my darling wife Eyitola, and my children Jide and Dehinde in Canada, Olubukola, Dr. Seyi in Saudi Arabia and the baby of the family, Oluwafemi. I must give a load of thanks to my siblings, brother Raphael in London, Grace, Alice and Dare. To my other brothers and cousins, who have touched my life positively in one way or the other, I say a big thank you. Specific mention must be of Olu Adebola (my GM), Professor Ade B. Adebola, the Consultant Maxo Facial Surgeon, Dr. Alaba Adebola, the Consultant cardiologist, Dr. Andrew Adebola , Dr. Tosin Adebola, the ENT Consultant, Dr. (Mrs.) Tosin Adebola, Dr. Solomon F. Adebola the Surgeon, Engr. Mike Adebola, Aunt Anna, Col. Biodun Dare, Major Gen. Owonibi and others too numerous to mention in this write up.

A strong academic foundation was laid for my educational pursuit, at St. Barnabas Secondary School, Kabba, where my

teachers then, mentors and god-parents, Mr. & Mrs. Allastair Campbell took special interest in me, and encouraged me academically, and more importantly, led me on the path of honour to the knowledge of Jesus Christ as Saviour in 1968. I am eternally grateful to this wonderful couple.

I cannot forget my teacher and friend in Titcombe College, Dr. Joel Aiyedun, I'm most grateful sir. At the higher levels of intellectual pursuit, I came across eminent scholars who in no small way, helped to shape my desire for and pursuit of deeper knowledge and wisdom. In this group, I must single out my teachers in Mathematics at the University of Ibadan, the late Prof. Olubunmo, the late Dr. Oyelese, Prof. Sowunmi, Dr. V. O. S. Olunloyo, former Governor of Oyo State, Prof. Akinyele, and Prof. Kuku.

Mr. Vice-Chancellor Sir, my acknowledgements will not be complete without mentioning my friends and colleagues in Kano State Polytechnic, Bayero University, Kano and University of Ilorin, Prof. Ajibero, former Rector, Kogi State Polytechnic, Prof. Fatope, Prof. Falola, Late Profs. Leo and Ayodele, Prof. Jackson Olujide, Prof. Adeyemi, Prof. Adewoye, Prof. Ajayi, (former Vice-Chancellor of Landmark University), Dr. Bamiduro, Mr Emman Obafemi (current Registrar at Unilorin), Prof. Oyejola, Prof. Adeyemo, Prof. Geju, Prof. Ibidunni, Prof. Tella, Prof. Olajide, Prof. Iwarere and others, too numerous to mention in this piece. I cannot forget my friends and cousins in diaspora, Prof. Dare Afolabi (USA), Prof. Isaac Megbolugbe (USA), Prof. Emmanuel Obasaju (UK), Prof. Mike Obasaju (USA), Mr. G.T. Aliu (rDCGC) and Mr. Koko Durowaiye.

Mr. Vice-Chancellor Sir, I remain eternally grateful to some eminent scholars, who have touched my life as mentors, leaders, and brothers. Special mention must be made, in this regard of Prof. Adekunle Alalade, a former Vice-Chancellor at Babcock University, Prof. Kayode Makinde, the immediate past Vice-Chancellor at Babcock University and Prof. Ekundayo Alao, my current boss and Vice-Chancellor at Adeleke University, Ede. These gentlemen have continued to serve committedly and eminently at their corners and duty posts in the Lord's Vineyard.

Mr. Vice-Chancellor Sir, I must return to the home front with loads of gratitude to Prof. Ademola Tayo, current Vice-Chancellor at Babcock University, Prof. I. Okoro and Prof. S. A. Owolabi, Senior Vice-Presidents at Babcock University, and Prof. A. D. Aina, current Vice-Chancellor at Caleb University, and other officers and associate officers in Babcock University management team. I must mention here that I remain most grateful for the opportunity to enable me present this Inaugural Lecture.

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I cannot conclude this without a special vote of thanks to Dr. Deji Adeleke, Founder and Chairman of Council, Adeleke University, Ede. The Lord will continue to bless you, and enlarge your coast, sir. Chief (Dr. Mrs.) Dupe Adeleke-Sanni, and Dr. Zacch Babarinde, both of Adeleke University, have proved their mettle as strong pillars of support. I am most grateful to them.

Mention must also be made of my late Royal Father (who passed on a few weeks ago). His Royal Majesty Oba M. F. Olobayo, the late Obaro of Kabba. He would very much have desired to be at this momentus event in my life. I must thank my colleagues at Adeleke University, especially my Deans, HODs, Directors and others who are committed to faithfully play their parts in moving Adeleke University forward. I must not forget to offer a big load of monumental gratitude to my secretary Mrs. Comfort Adeleke, and Mrs. Fatade, who typed the manuscript

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Finally, thanks go to members of this audience, especially my friends, relations and colleagues who have come from far and near, just to see me deliver this lecture. The Lord will continue to honour you. Amen.

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PREVIOUS INAUGURAL LECTURES

1. "Seventh-day Adventist Church in Nigeria since 1914: An Impact Analysis."
   Lecturer: Prof. David O. Babalola
   Date: Thursday, December 2, 2010

2. "The Truth about Truth: Postmodernism and its Epistemological Implications for Christian Education"
   Lecturer: Prof. Ademola Stephen Tayo
   Date: Thursday, February 5, 2015

3. "Food for Though in Thoughts for Food: Conceptual Genius of Local Ingredients in Global Diets and Food Habit of African Population"
   Lecturer: Prof. Yetunde Olawumi Makinde
   Date: Thursday, April 2, 2015

4. "One Kingdom, Many Kings: The Fungi-once Sidelined and Maligned, now Irrepressible and Irresistible."
   Lecturer: Prof. Stephen Dele Fapohunda
   Date: Thursday, May 2, 2015

5. "The Hand that Handles the Scalpel"
   Lecturer: Prof. Iheanyichukwu Okoro
   Date: Wednesday 10th June, 2015

6. "Parasitic Infections: Challenges of Control and Eradication in Public Health"
   Lecturer: Prof. Dora Oluwafunmilola Akinboye
   Date: Thursday, 15th October, 2015

7. "The Oracle, Intellectual Property and Allied Rights, the Knowledge Economy and the Development Agenda"
Lecturer: Prof. Bankole Sodipo
Date: Tuesday, 17th November, 2015

8. "Challenges of University Education Quality in Nigeria: Placing Emphasis where it Belongs"
Lecturer: Prof. James Ahamefule Ogunji
Date: Thursday 4th February, 2016

9. "Factionalism, Rampaging Economic Vampires, and the Fragile State"
Lecturer: Prof. Ayandiji Daniel Aina
Date: Wednesday, March 9, 2016

10. "Footprints: Livestock Nutrient Management and the Environment"
Lecturer: Prof. Grace Oluwatoyin Tayo
Date: Thursday, April 7, 2016

11. "Nursing on the move: Consolidating and Harnessing the Gains for Clinical Excellence"
Lecturer: Prof. Ezekiel Olasukanmi Ajao
Date: Thursday, May 5, 2016

12. "Accounting in the Digital Age: Creating Values with Paperless Decision Support Systems"
Lecturer: Prof. Enyi Patrick Enyi
Date: Thursday, September 8, 2016