The point of op risk

The inclusion of an explicit operational risk component in the proposed Basel II Capital Accord has caused widespread controversy. Much of this has surrounded the feasibility of accurately measuring, or even defining, such risk. In this first of three columns, David Rowe argues that a more important goal should be to improve the consistency of banks' internal process execution

ore than 50 years ago, following their country's defeat in World War II, some forward-looking Japanese business leaders sought ways to boost the country's economic recovery. In their search to achieve a competitive edge, they believed improved product quality was a key requirement. At the time, to put it bluntly, 'Made in Japan' was a joke, synonymous with cheap products and shoddy workmanship. In seeking to change that reputation, Japanese business leaders were impressed by the work of a US citizen, W Edwards Deming. He taught Japanese industrial leaders the techniques of statistical process control and thereby triggered a revolution.

In 1970, I bought a Toyota sedan and received some good-natured jibes from my students. "Does it say 'Made in Japan'?," they would ask. This only shows that perceptions inevitably lag reality, since by then Japanese workmanship had long since surpassed that of comparable US products. Sadly, this reality was understood far sooner by US consumers than by US industrial and labour leaders. The result was a long and protracted decline in the domestic share of total US auto sales, which paralleled a similar trend in other industries.

Experience is a harsh but ultimately effective teacher. Eventually, US management and labour came to grips with their quality control problem by embracing the lessons already well embedded in Japanese manufacturing. Slowly, the quality of US products began to improve and, by the time he retired, one of the legendary Jack Welch's much-touted innovations at General Electric was the introduction of six-sigma quality control methods.

Many theories have been advanced as to why Western business was so slow to react to the challenge of quality improvement. One possible reason is that financial executives tended to dominate the executive suite, while operations management was a less highly regarded discipline. Whether or not this was true of industrial corporations 25 years ago, it is certainly true of most financial institutions today. One does not have to spend much time in banks to know that, with a few notable exceptions, operations staff are second-class



management at SunGard Trading and Risk Systems e-mail: david.rowe@risk.sungard.com

citizens. This is compounded by the enduring truth that what cannot be measured cannot be controlled, combined with the mistaken belief that quality cannot be measured. All the same arguments on this score that we hear today from banks were put forward by the manufacturing sector in the 1960s and 1970s. What Deming did was to prove that quality could be measured, albeit with metrics that have a different character and feel from those of traditional accounting and finance.

A key distinction in risk management is between metrics that are commensurable and those that are appropriate. Commensurable metrics can be combined in a structured way to produce a single aggregate measure. The most familiar of these is unexpected losses expressed in the value of a specific base currency. Appropriate measures are generally not commensurable because they have radically different dimensions.¹ Nevertheless, they are important for daily risk oversight because they reflect specific characteristics of a given activity.

An appropriate analogy is the complex bank of instruments in the console of an aircraft.² These give a wide variety of detailed readings, such as the fuel level, the altitude, the external air temperature, the head or tail wind, the ground speed, the directional heading and many more. Collectively, these cannot be combined into a single 'risk metric', although an out-ofpattern reading for any one may trigger a warning alarm. The key point is that the mere presence of an alarm does not provide any clue as to the specific problem.

Deming distinguished between special causes and common causes of operational risk failures. Special causes are local in nature and can be solved directly by people performing a task or by their immediate supervisors. Common causes remain after special causes have been eliminated. They are due to the design or the operation of the process or system. They may be identified by the operators, but only management authority can eliminate them. Deming's early research led him to believe that more than half of all operational failures were attributable to common causes, and his estimate of this proportion increased throughout his career.

The essential point is that most operational failures cannot be reduced by exhorting staff to work harder or be more careful. Management must actively and regularly evaluate the processes performed to fulfil an organisation's mission and assess common causes of operational failures, as well as the controls intended to prevent such failures. The goal of such evaluations is to revise the processes and/or the controls as needed to achieve the desired level of consistency in execution. Between such qualitative reviews it is also essential to generate regular performance data to monitor whether each process is continuing to be performed with the desired quality and consistency.

Too much of the current discussion of the Basel II operational risk capital charge has centred on the collection and analysis of loss data. While this is important, its impact pales in importance relative to serious management attention to improving process execution. While frequent hints point to an underlying supervisory emphasis on the fundamental process improvement dimension of operational risk, it would be valuable for the Basel Committee and national supervisors to be more explicit in this regard. ■

 ¹ Of course, it is possible to use arbitrary weights to combine non-commensurable measures into some sort of index that may be useful
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