

## **Executive Summary**

# **Microenterprise in the U.S.: Is There a Case For Public Support?**

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The purpose of this paper is to examine whether there is a case for public funding of microenterprise development (MED) in the U.S. Supporters and critics of MED make a variety of arguments for and against public support of the MED strategy. The paper presents and assesses the arguments for and against public support, identifies the challenges faced by the MED field in the U.S., and discusses possible strategies for addressing these challenges.

Four arguments for public support of the MED strategy are presented and assessed. They are: (1) MED is a positive response to structural changes in the economy and the workforce; (2) MED services help maximize the human and economic resources of our country; (3) MED programs fill a gap that the market has failed to serve; and (4) the MED strategy has the potential for substantial macroeconomic impact and high return on investment. In analyzing this fourth issue, the potential annual net benefit of MED services is estimated, based on varying assumptions, to range from \$10.5 billion to \$27.2 billion in personal income and reduced welfare expenditures. Not included in the calculations are new annual revenues from sales, income, and property taxes, nor the estimated increase in net assets by business owners of \$3.3 billion over five years, nor the possible “displacement” effects for existing businesses. The investment required to generate this economic impact is estimated to range from \$5.1 billion to \$10 billion in business development services and costs of lending. The consequent return on investment is estimated to range from \$2.06 to \$2.72 for every dollar invested.

Four arguments against public support of MED are presented and assessed. They are: (1) MED is not a solution to urban poverty; (2) MED programs do not serve the most disadvantaged; (3) even if MED programs served the most disadvantaged, most of the businesses will generate only marginal income for the business owners; and (4) the MED strategy is a relatively costly and time-consuming path to economic self-sufficiency. The first argument is found to be without merit. The other three arguments raise issues that have merit; there are factors that explain the limited accomplishments at this point in the development of the field, but the issues need to be addressed as the field continues to move forward.

Three challenges are presented. The first and most important is the need to build the MED strategy into the mainstream employment systems so that everyone has the right and

opportunity to choose the self-employment option if it seems the most fulfilling and the most likely to produce a decent living and allow individuals to contribute to the economy. This is also critical because the resulting larger numbers and more diverse populations will reduce the unit cost per outcome for MED programs. Achieving this goal will require commitment from legislative bodies, government agencies, and MED programs who will need to collaborate to make major changes in policies, program designs, capacity, operating procedures, and tracking and documenting outcomes. Such integration should, in the long term, result in stable, mainstream funding for MED services.

The second challenge is to identify, document, and disseminate the lessons learned and best practices in the MED field. One level of this documentation should focus on the issues that need to be addressed when agencies are considering whether to undertake a MED program. Another level should focus on later-stage issues such as marketing, training and technical assistance, loan products, partnerships, management information systems, administrative structures and systems, and policy advocacy. Special emphasis should be placed on best practices that enable programs to move into the mainstream employment systems and build capacity for major increases in program scale.

The third challenge for the MED field is to build a culture that focuses on program performance and return on investment. Funding should carry with it specific outcome expectations that reflect what is known about performance, and those outcomes should be monitored regularly. The performance measures should require that MED programs identify and work toward specific outcomes, but also specify costs per outcome, within a context that recognizes variations based on the target population being served. Performance standards must move beyond “outputs,” such as business starts, to longer-term outcomes, including business survival and income produced. In order to take into consideration the wide range of client objectives for self-employment, data should relate the income objectives to the outcomes/results. Also, researchers need to find effective ways to determine real income from businesses and how that relates to the income needs of the business owners’ households. Finally, there is need for good data on return on investment. There is little data at this level. The field is now sufficiently mature to be measured at these levels.

The MED strategy was late in coming to the U.S. The way that it emerged and the organizations that accepted the challenge to demonstrate its importance and effectiveness in the U.S. context have, in large part, shaped its current status in this country. The challenge of the future is to recognize and acknowledge the advantages and the disadvantages that are linked to this history, to envision the potential contributions of the MED strategy within our nation, and to work to create whatever structures and systems are necessary to realize that potential.