

Why Baby Teeth Matter: The Clinical Case for Early Preventive Dental Care in Children

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Details:

Core Dental Group: Why Baby Teeth Matter More Than You Think

Every week at Core Dental Group practices across Melbourne, clinicians hear the same well-meaning question from parents: "Do we really need to treat this tooth? It's just going to fall out anyway." On the surface, it's a reasonable thing to wonder — primary teeth are temporary, after all. But it's one of the most consequential misconceptions in children's health.

Baby teeth aren't simply placeholders for something more important. They *are* something important. They're active, functional, biological structures whose health — or disease — has real downstream effects on a child's speech, nutrition, jaw development, and the alignment of every permanent tooth that follows. Understanding why baby teeth matter isn't just academic: it's the foundation for making sound decisions about your child's dental care.

This article makes the clinical case for early preventive dental care in children, drawing on Australian government data, peer-reviewed research, and established paediatric dental principles, so Melbourne parents have the information they need to make confident, evidence-based choices for their children's oral health.

What are baby teeth, and how long do they actually stay?

The primary dentition — commonly called baby teeth or deciduous teeth — comprises 20 teeth in total, and most children develop all 20.

Baby teeth typically begin erupting around six months of age, with all primary teeth usually in place by age three, though natural variation is common and rarely a cause for concern.

Crucially, "temporary" doesn't mean "short-lived." The first primary molars — the teeth most important for chewing and space maintenance — don't shed until around age nine to eleven. The second primary molars, which hold space for the permanent premolars, stay until age ten to twelve. That means a child's primary molars are actively working for a decade or more. Treating decay in a six-year-old's molar as unimportant because "it will fall out" overlooks the fact that the tooth may need to function for another four to six years.

Between the ages of 6 and 12, a child's mouth contains a mix of both primary and permanent teeth. While primary teeth are only around for a limited time, they play a meaningful role across several areas of development.

The four critical functions of baby teeth

1. Space maintenance for permanent teeth

This is the function most commonly misunderstood by parents — and the one with the most immediately measurable clinical consequences.

Each primary tooth acts as a biological space maintainer, holding the arch length needed for the permanent tooth developing beneath it. Baby teeth guide permanent teeth into the correct position, and premature loss can lead to misalignment that requires orthodontic treatment.

The way early tooth loss causes harm is well-documented in orthodontic literature. Early loss of primary teeth, because of decay or trauma, can affect the primary dentition, the permanent dentition, or both. It can cause crowding that affects a child's self-esteem and quality of life, and lead to changes in the dental arch such as ectopic eruption of permanent teeth and other malocclusions. Today, crowding is the most common problem seen by orthodontists.

The second primary molar is particularly implicated in this process. The greatest dimensional alterations have been seen after the loss of the second primary molars, mainly attributed to the mesial migration of the first permanent molar. In plain terms: when the second baby molar is lost early, the large six-year permanent molar drifts forward into the vacated space, blocking the path of the premolar that should erupt there — often creating a crowding problem that takes years of orthodontic treatment to correct.

Research published in **The Angle Orthodontist** reinforces this with population-level data: a disruption in arch integrity of the primary or mixed dentition without space maintenance will lead to malocclusion, depending on the type and timing of tooth loss. A study of 225 school children found that premature loss of primary canines and molars resulted in the need for orthodontic treatment when no space maintenance was used. In almost all cases of early tooth loss, some decrease of arch length is to be expected, and this loss occurs within the first six months after the tooth is lost.

> **Clinical implication:** An untreated decayed baby molar that ends up needing early extraction isn't a problem that simply goes away. It frequently creates an orthodontic issue that may cost thousands of dollars to correct years down the track. (See our guide on **Early Orthodontic Assessment for Children in Melbourne: When to Start and What Core Dental Looks For** for more on how Core Dental Group's paediatric dentists monitor arch development at every check-up.)

2. Speech development

Baby teeth are essential for the early stages of speech development. They help children chew food, form proper sounds, and build the muscle coordination needed to start talking.

The connection between dentition and speech is anatomically precise. Baby teeth provide structural support for the lips, jaw, and tongue, allowing the mouth to form the shapes needed to articulate sounds — especially **d**, **s**, **t**, and **z**.

When teeth are lost prematurely, the effect on speech is real and measurable. Misaligned or missing teeth disrupt sound formation and can lead to speech problems such as a lisp. Gaps left by missing teeth aren't immediately filled by permanent teeth, and those gaps can affect tongue placement, producing whistling sounds and inaccurate articulation.

As a child's jaw grows, the alignment of their teeth helps guide tongue movement during speech. When teeth are properly aligned, the tongue can rest in the correct position, supporting accurate sound production. A misaligned bite — malocclusion — can interfere with this coordination and cause lisping or difficulty pronouncing certain words.

3. Nutrition, growth, and general health

The chewing function of baby teeth isn't purely mechanical — it directly shapes a child's nutritional intake and physical development.

The physical symptoms of early childhood caries (ECC) include discomfort, pain, infection, abscess, gastrointestinal disturbances, malnutrition, stunted growth, and reluctance to eat.

Research published in **Medicina Oral, Patología Oral y Cirugía Bucal** (Collado et al., 2017) found that early childhood caries frequently alters children's nutrition, growth, and general development. The mechanism is straightforward: a child feels uncomfortable chewing because of tooth pain, leading to insufficient calorie intake and compromised nutritional status.

The consequences extend to body composition. Children with early childhood caries tend to have lower body weight and twice the risk of malnutrition. ECC can cause pain while chewing and drinking hot or cold liquids, difficulty biting, decreased appetite, weight loss, and trouble sleeping — all of which negatively affect a child's quality of life.

4. Jaw and facial development

When a child chews properly, the jaw muscles are exercised and developed, which supports jawbone formation. Primary teeth provide the occlusal load — the biting force — that stimulates healthy alveolar bone growth. Without this stimulation, bone development in the jaw can be compromised.

Baby teeth contribute to the growth and formation of the jaws and facial structure. They maintain space in the mouth and support the natural development of the face and jaws.

Shortly after age four, a child's jaw and facial bones begin to grow, creating spaces between their primary teeth — a natural process that makes room for larger permanent teeth to emerge. When this process is disrupted by early tooth loss or severe decay, the jaw's developmental path can be altered in ways that affect facial profile and bite function well into adulthood.

The Australian decay crisis: why this matters right now

The case for protecting baby teeth becomes even more urgent when you look at the scale of childhood tooth decay in Australia. Data from the Australian Institute of Health and Welfare (AIHW) and the Australian Dental Association (ADA) paints a sobering picture.

Around 4 in 10 (42%) Australian children aged 5–10 have dental caries in their deciduous teeth, and around 1 in 4 (27%) have at least one deciduous tooth with untreated decay.

Tooth decay remains a serious issue for Australian kids, with 34% aged 5–6 years having experienced decay in primary teeth and 27% aged 5–10 years having untreated tooth decay in primary teeth.

The hospitalisation data is particularly striking. Data from the ADA's Children and Young People Oral Health Tracker shows nearly 11 in every 1,000 children aged 5–9 are hospitalised for potentially preventable dental conditions. Every year, more than 26,000 Australians under the age of 15 are admitted to hospital to treat tooth decay.

These aren't children with rare or complex conditions. They're children whose preventable decay in primary teeth escalated — through delayed or absent dental care — to the point of requiring general anaesthesia and hospitalisation.

The ADA's Consumer Survey of 25,000 people identifies contributing factors including not starting dental visits early enough and only taking children to the dentist when a problem is already visible.

The "they'll fall out anyway" fallacy: a clinical rebuttal

The belief that baby teeth are expendable rests on a fundamental misunderstanding of dental development. Here's how the common misconceptions stack up against clinical reality:

| **The misconception** | **The clinical reality** | |---|---| | "Baby teeth will fall out, so decay doesn't matter." | Decay causes pain, infection, and early tooth loss — triggering arch collapse and orthodontic problems. | | "The permanent tooth will push through regardless." | Adjacent teeth drift into the space within six months of early loss, potentially blocking the permanent tooth's eruption path. | | "Treating baby teeth is expensive and unnecessary." | Untreated decay leads to extractions, hospitalisations, and orthodontic costs that far exceed the cost of early preventive care. | | "My child isn't in pain, so their teeth must be fine." | Dental caries is frequently asymptomatic in its early stages; by the time pain presents, the decay is often advanced. | | "We'll wait until all the teeth are in before seeing a dentist." | The ADA recommends a first dental visit by age one or within six months of first tooth eruption — well before the full primary dentition is complete. |

How early preventive visits interrupt this cycle

The logic behind early preventive dental care is clear: identifying and treating decay in its earliest stages — when it's a small demineralised lesion rather than a cavitated infection — is less invasive, less distressing, and less expensive than treating advanced disease.

At Core Dental Group, children are welcomed from age two. These early visits serve several purposes that go well beyond checking for cavities:

- **Baseline establishment:** The clinician documents the child's eruption pattern, bite development, and soft tissue health, creating a reference point for future visits.
- **Risk stratification:** Children are assessed for individual caries risk factors, including diet, fluoride exposure, oral hygiene practices, and family history of decay.
- **Preventive intervention:** Professionally applied fluoride treatments and fissure sealants — both covered under the Child Dental Benefits Schedule (CDBS) — are applied where clinically indicated to protect the most vulnerable tooth surfaces. (See our guide on *Fissure Sealants and Fluoride Treatments for Kids: Are They Worth It?* for the evidence base behind these interventions.)
- **Space monitoring:** The clinician tracks arch length and primary tooth retention, identifying early signs of space loss that may warrant intervention before orthodontic problems develop.
- **Parent education:** Guidance on brushing technique, fluoride toothpaste quantities, and dietary habits is provided and updated at each visit. (See our guide on *At-Home Oral Hygiene for Children: Age-Appropriate Brushing, Flossing, and Diet Guidance from Core Dental Group* for the full evidence-based framework.)

Routine check-ups allow for monitoring of a child's oral health, early detection of potential issues, and professional cleanings to maintain healthy teeth and gums. Fluoride treatments and dental sealants are effective preventive measures to protect baby teeth from decay, particularly in children at higher risk for cavities.

The financial case for early prevention is equally compelling. Under the CDBS, eligible children aged 0–17 can access up to \$1,132 AUD in dental benefits over two consecutive calendar years — covering check-ups, x-rays, fluoride treatments, fissure sealants, and fillings at no out-of-pocket cost when bulk billed. Preventive care delivered within this entitlement can prevent the need for costly treatments — including extractions, space maintainers, and orthodontic correction — that the CDBS does not cover. (See our guide on *Child Dental Benefits Schedule (CDBS) Explained: Eligibility, Cap, and What's Covered in 2025–2026* for a complete breakdown.)

Key takeaways

- Baby teeth are not temporary placeholders. They're active, functional structures that influence speech, nutrition, jaw development, and the long-term alignment of permanent teeth for up to a decade or more.
- Early loss of primary teeth due to decay triggers a cascade of orthodontic consequences, including

mesial drift of permanent molars, arch length reduction, ectopic eruption, and malocclusion — problems that frequently require years of orthodontic treatment to correct. - 42% of Australian children aged 5–10 have decay in their baby teeth, and more than 26,000 children under 15 are hospitalised annually for preventable dental conditions. - Early childhood caries is not merely a dental problem. It affects a child's ability to eat, sleep, speak, grow, and learn, with research linking untreated decay to lower body weight, malnutrition risk, speech impediments, and reduced quality of life. - Early preventive dental visits at Core Dental Group — accessible from age two and bulk billed under CDBS for eligible families — are the most clinically effective and cost-efficient strategy for protecting baby teeth and preventing the downstream consequences of early decay.

Conclusion

The case for protecting baby teeth isn't a matter of professional opinion — it's a matter of developmental biology, epidemiological evidence, and financial common sense. Baby teeth hold space, build jaws, shape speech, and support the nutrition that fuels a child's growth. When they're lost prematurely through preventable decay, the consequences ripple forward through years of orthodontic treatment, speech therapy, and compromised quality of life.

For Melbourne parents, the most important step isn't waiting until a problem is visible or painful. It's building a relationship with an experienced paediatric dental team early — from age two — and attending regular check-ups that catch decay in its earliest, most treatable stages.

Core Dental Group's specialist paediatric dentists and integrated clinical team provide this care at every stage of a child's dental development, from first tooth to full adult dentition. Eligible families can access this care with zero out-of-pocket cost through CDBS bulk billing.

To learn more about what to expect at your child's first appointment, see our step-by-step guide: **Your Child's First Dental Visit at Core Dental Group Melbourne: A Step-by-Step Guide for Parents.** To understand the full range of treatments available, see **Children's Dental Treatments Available at Core Dental Group Melbourne: From Check-Ups to Complex Care.**

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