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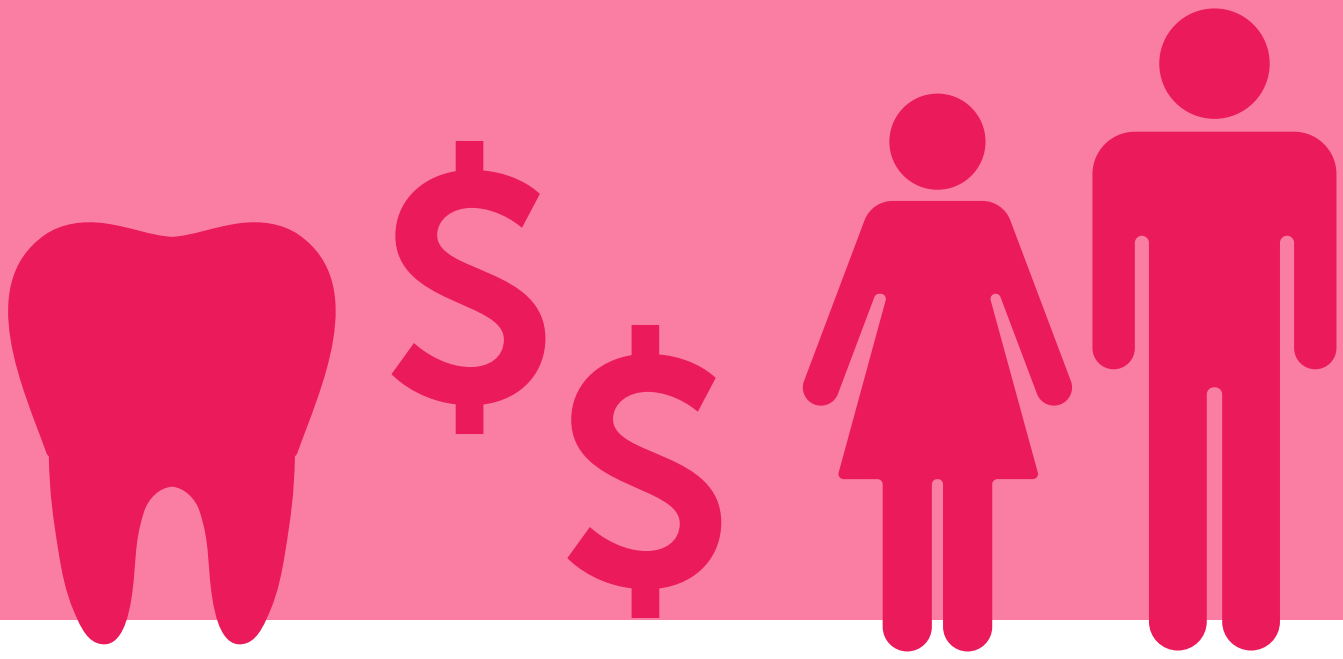
Creating a Nation of
Happy, Healthy Smiles

2025

POVERTY SHAPES ORAL HEALTH

WHITE PAPER

Learn how poverty has a profound and detrimental impact on children's oral health, leading to lasting disparities into adulthood.



INTRODUCTION

Poor Oral Health is a Marker of Socioeconomic Inequality

Oral diseases hit disadvantaged populations hardest. Globally, people with lower socioeconomic status have a higher burden of dental disease across their lifetime (1).

Roughly half of U.S. kids lack routine dental care due to social, economic, and geographic hurdles (2).

Oral health is a fundamental component of overall health and well-being, essential for proper nutrition, speech, self-esteem, and social interaction (1). Yet, our oral healthcare delivery system in the U.S. does not adequately protect disadvantaged populations of Americans from dental disease. As a leading dental healthcare delivery organization committed to providing quality care to more than one hundred underserved communities in the United States, Benevis recognizes the critical role of oral health in the lives of children, having cared for the dental needs of more than 500,000 young patients in 2024.

Socioeconomic factors, particularly poverty, create significant barriers to achieving and maintaining good oral health for millions of children in the U.S. From rapidly rising dental care costs and accessible care to unaffordable oral health insurance—these hurdles have become insurmountable for too many (2).

In this white paper, Benevis illuminates how being poor shapes children's smiles into adulthood. We examine the data behind dental disparities relative to income, exploring the relationship between income and social determinants of oral health, discussing the role of Medicaid and CHIP, and proposing recommendations for future action to advance dental health equity for the most vulnerable populations.

*Dental caries is defined as the disease that causes tooth decay.

EXECUTIVE SUMMARY

Poverty Shapes Smiles

Growing up poor has a detrimental and even devastating impact on children's oral health, leading to significant disparities that persist into adolescence and adult years (2).

Early disadvantages in life can have a longer-lasting impact on oral health through adulthood (3).

More than 11 million (13.7%) children in the U.S. live in poverty. In as little as two years from 2021 to 2023 that number has grown substantially by 7.2 million children (4). Unfortunately, social patterns in oral disease are prevalent for the poor (1). Children from low-income households experience a higher rate and severity of dental caries (tooth decay) from preschool years through adolescence (3). This disparity manifests as more untreated decay, greater tooth loss, and poorer oral health relative to life quality. The consequences of poverty on oral health extend beyond childhood, with working-age adults more likely to experience higher rates of tooth loss and untreated decay (2). **Social determinants of health, including insufficient dental insurance coverage, limited access to dental care, and poor health education and nutrition, are closely connected to income, deepening the level of disparity for the disadvantaged (1).**

Although programs like Medicaid and the Children's Health Insurance Program (CHIP) have made strides in improving access for some children, significant gaps still exist (5). Addressing these inequities requires comprehensive and collaborative efforts from policymakers, healthcare providers, educators, and communities to ensure all children have an equal opportunity for healthy smiles, regardless of their socioeconomic circumstances.

EARLY CHILDHOOD

Data Behind Dental Disparities Relative to Income

Income serves as a critical differentiator in the dental disparities of children. Preschool children living in poverty experience a significantly higher burden of early childhood caries (6).

Poor children aged 2–5 have twice the decay of non-poor children (6).

About 1 in 3 preschoolers living in poverty have some form of early childhood caries, and they have higher levels of dental decay compared to non-poor children. This disparity is further highlighted by the fact that children aged 2 to 5 years living below the poverty threshold have considerably more decayed or filled primary teeth than their counterparts from higher-income families (6).

These disparities persist into school-age years. More than 1 in 5 Mexican American and non-Hispanic Black children aged 6 to 11 experience tooth decay, whereas fewer than 1 in 7 non-Hispanic White children do. Notably, about 1 in 4 impoverished children of the same age have tooth decay in permanent teeth versus nearly 1 in 8 children living in households at twice the federal poverty level or above it (1).

While there has been improvement in school-aged children's dental health over the last decade, those who grow up poor continue to bear a disproportionate burden of untreated decay. Untreated dental caries in 5 to 11 year-old children living in poverty are more than two times higher (23%) than for children with family incomes at or above 200% of the poverty level (9%) (7).

ADOLESCENCE

Data Behind Dental Disparities Relative to Income

The trend of poverty-related dental disparities during childhood continues into adolescence. Adolescents from low-income families experience greater barriers to care and higher rates of decay (6).

Low-income adolescents have two times the untreated decay of high-income adolescents (6).

Dental disparity deepens relative to adolescents' poverty status. More than half of adolescents aged 12 to 19 have dental caries (57%), with a much higher prevalence among those living in poverty (65%) compared to their more affluent peers of the same age (49%) (2). Although race and ethnicity factor into the number of dental caries that Mexican American (70%), non-Hispanic Black (57%), and non-Hispanic White (54%) adolescents experience, growing up in poverty is the greatest influencer of tooth decay (8). Dissimilar to preschool children, poor adolescents have higher rates of dental caries than non-poor adolescents regardless of race or ethnicity (2).

The disparity is even greater for untreated dental caries, affecting twice as many (15%) 12 to 17-year-olds living in poverty versus 6% of adolescents with family incomes at or above 200% of the poverty level (7). **With dental caries prevailing in the U.S. as the most prevalent chronic disease of children and teenagers from ages 6 to 19, pediatricians play a pivotal role in providing this younger population with dental referrals and helping them establish a dental home that delivers continued preventative oral care (9).**

WORKING-AGED ADULTS

Data Behind Dental Disparities Relative to Income

Having a greater number of dental caries in childhood and adolescent years leads to the development of more caries in adult years (10). Those dental health disparities are even greater for poor and minority adults (6).

Older lower-income adults have triple the amount of untreated decay vs. older higher-income adults (2).

The cumulative effects of childhood and adolescent dental disparities linked to poverty are evident in working-aged adults. Edentulism (complete tooth loss) is significantly higher among adults in poverty, with an estimated 6% of poor adults aged 20 to 64 edentulous, compared to 2.2% overall. That number increases for older working-aged adults (50-64 years) living in poverty, with more than 17% experiencing complete tooth loss. In the same age group, only 47% of poor adults have a functional dentition (at least 21 teeth), compared to 83% of non-poor adults aged 50 to 64 (2).

Untreated dental caries are also substantially more prevalent for adults living in poverty. Among adults with lower incomes, 41% have untreated dental decay versus only 18% of those with incomes at least twice the federal poverty level. For older, poor adults, 33% are affected by untreated caries compared to only 10% of their higher-income counterparts (2). **Financially, families living in poverty face a disproportionate burden, spending almost seven and a half times more of their annual income on dental care as a percentage compared to high-income families.** Additionally, poor individuals reported unmet dental care needs at a much higher rate, with 27% citing at least one dental visit in the previous year compared to 55% from the high-income group. The nearly 30% disparity and deficit in preventive dental care held steady for 14 years between 2007 and 2021 (11).

SOCIAL DETERMINANTS OF HEALTH

SDOH Relationship to Income

Social determinants of health (SDOH) are the conditions that people are born into, grow up around, and work and live in through a lifetime. Each factor affects a person's day-to-day living and health (12). Income is a fundamental SDOH that can significantly shape oral health outcomes (13).

"Social, behavioral, and economic conditions represent 90% of all health outcomes (14)."

"Growing up poor can create numerous disadvantages that impact oral health. At Benevis, we're teaming up with payers, providers, and policymakers to make sure every child receives high-quality dental care," said Dr. Dale Mayfield, DMD, Chief Dental Officer at Benevis.

Here are a few areas where dental disparities are deeply felt:

Affordable Access to Care: Cost is the greatest barrier to dental care access. Nearly 12% of Americans did not receive necessary dental care because they could not afford it (15). For individuals living in poverty, dental spend as a percentage of total income is high, making many dental services unaffordable. Adults with lower incomes are substantially less likely to have seen a dental provider within the past year than adults with higher incomes (11).

Insurance Coverage: Economic and income factors play a critical role in families' ability to access routine dental care, particularly dental insurance. According to the 2024 State of Oral Health Equity in America survey, nearly 27% (72 million) of adults in the U.S. have no dental insurance coverage (16).

Geographic Accessibility: Dental services may be harder to find in areas where many people with lower incomes live, partly because payment structures provide lower incentives for providers to locate in these areas (17). With few dentists participating in Medicaid or Children's Health Insurance Program services, low-income families are at a greater disadvantage in finding convenient, quality dental care (18).

Health Literacy: Low health literacy, including understanding insurance benefits, is linked with lower use of preventive healthcare and is more common among people with low incomes (19). People who are poor and less educated are also much less likely to have dental insurance than those who are not (11).

DENTAL INSURANCE

Important Role of Medicaid and CHIP Programs

State Medicaid and the Children's Health Insurance Program (CHIP) have played a crucial role in improving access to dental services for poor and near-poor children and adolescents.

67% of dentists in the U.S. do not treat any children with Medicaid benefits (18).

These programs have substantially facilitated the use of dental services among disadvantaged populations, leading to a near-doubling of the percentage of children with public dental insurance between 1996 and 2015. This increase in public coverage has contributed to a significant rise in overall dental coverage among children (20). Today, 38% of children ages 0 to 18 rely on Medicaid or CHIP dental benefits (21).

Despite these positive impacts, disparities persist within the publicly funded programs. Non-Hispanic Black and Hispanic children are more likely to rely on public dental insurance and, more critically, children with public insurance often receive less dental care than those with private coverage (22). This is frequently attributed to lower rates of reimbursement by Medicaid in many states, which results in a smaller network of dentists willing to provide services to Medicaid patients (23). **Only 18% of dentists nationwide, including Benevis, manage 100 or more child Medicaid visits each year (18).** These limitations in provider participation limit access and use of regular dental services, particularly preventive care (24).

Adult dental benefits for Medicare and Medicaid also vary considerably by state and as a result approximately one-third of beneficiaries are without dental coverage (16). On July 3, 2025, legislators passed a bill implementing Medicaid work requirements, which will make it more challenging for poor Americans to receive dental care. The Congressional Budget Office estimates that 8.6 million more people will be uninsured by 2034, adding a greater cost burden to our strained healthcare system (25). Such hurdles in access and coverage for both children and adults emphasize the need to strengthen and improve these vital programs.

RECOMMENDATIONS

Taking Action to Address Poverty and Oral Health

Addressing the profound impact of poverty on children's smiles requires a multi-faceted and sustained effort. The following recommendations aim to advance dental health equity in the U.S.:

Expand Access to Affordable Dental Care: Increase the number of dental providers serving low-income communities through financial incentives, loan repayment programs, and support for community-based dental clinics and school-based health centers.

Enhance Medicaid and CHIP: Advocate for increased Medicaid reimbursement rates for dental services to improve provider participation and ensure children with public insurance have access to a comprehensive range of care. Explore options for expanding adult dental benefits within Medicaid.

Promote Early Preventive Care and Education: Invest in and expand early childhood caries prevention programs, focusing on educating parents and caregivers about oral hygiene, healthy diets, and the importance of early dental visits. Integrate oral health education into pediatric medical visits and other community programs serving low-income families.

Address Social Determinants of Health: Implement policies and programs that address the underlying social and economic factors contributing to oral health disparities. This includes initiatives aimed at reducing poverty, improving access to nutritious food, and enhancing educational opportunities. To support improvement, healthcare providers, social service agencies, educators, and community organizations must work together.

Improve Health Literacy and Health Insurance Literacy: Develop culturally appropriate oral health information and resources tailored to the needs of low-income populations, and provide assistance in understanding and navigating dental insurance options and benefits.

CONCLUSION

Poverty's Lasting Impact on Oral Health

Poverty is consistently highlighted as a major factor in oral health disparities across different age groups in the U.S. Socially marginalized children, including poor and racial and ethnic minorities carry the heaviest burden of oral diseases (2).

Living below 200% of the federal poverty level doubles children's and adolescents' incidence of dental decay (6).

The evidence overwhelmingly demonstrates that poverty casts a long shadow over children's smiles, creating profound and persistent dental health disparities that extend into adulthood. These inequities are not merely a matter of oral health; they are a reflection of broader social and economic injustices that impact overall well-being and life opportunities. Addressing these disparities is an ethical imperative and a critical step towards achieving health equity for all children in the United States. By implementing comprehensive and collaborative strategies that tackle the root causes of these inequities, we can work towards a future where every child, regardless of their socioeconomic background, has the opportunity to develop and maintain a healthy smile.

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Benevis is a leading dental healthcare organization for practices focused on delivering critical oral care and orthodontics to underserved communities. Through comprehensive care and operational services that expand access to dentistry, Benevis has a 20-year history of providing the highest quality care to approximately 5 million children and adults. Its network reaches more than 100 dental offices across the U.S. that deliver treatment during 1.4 million visits each year. Benevis also advocates for programs and legislation that ensure all families have access to the oral healthcare they need and deserve.

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