Health care systems throughout the world are currently undergoing major reforms; countries like Italy, and even small places like Malta, are no exception. The increasing demands of modern medicine with dramatic improvements in technology, as well as chronic diseases of the elderly, are increasing the pressure on health care budgets. Various measures are being taken by health authorities to try to contain costs. In Italy, in particular, medical manpower has been reduced and new recruitment suspended; indeed, medical unemployment in Italy is among the highest in the European Community. Resources tend to be allocated to larger hospitals, leading to the progressive change of the role of smaller central and peripheral hospitals. To reduce costs, many of these hospitals are gradually transforming themselves into specialist out-patient clinical centres.

The crisis in the Italian public health system is mirrored in academic medicine. The main reasons for this are that funding has been severely reduced and major restrictions have been imposed by previous administrations on the financial support that was being granted by the pharmaceutical industry. This caused significant reductions in financial resources and has drastically influenced the budget of each university. Thus, whereas before 1993 universities' budgets were completely funded by the state, this source of funding has only been partial since then. As a result, each university is currently passing through a phase of generating its own budget in order to support research. Apart from these financial constraints, the academic world has been hit by a major setback as recruitment of academic staff is currently at a standstill.

The whole medical community is affected by this situation, not least the two sister specialities of rheumatology and dermatology. These two disciplines are involved in the care of several diseases that share cutaneous, visceral and locomotor system involvement, such as connective tissue disorders (systemic lupus erythematosus, scleroderma, dermatomyositis), seronegative arthropathies (psoriatic arthritis, Reiter's disease), several vasculitides, as well as certain infections such as Lyme borreliosis. In Italy, dermatology and rheumatology are autonomous, both having a residency programme of 4 yr completely separated from internal medicine. In Malta, the situation is different as rheumatology still forms part of the department of internal medicine, while dermatology will imminently attain separate status, but will retain close and vital links with this department. Trainees in both specialities spend some time in each other's departments and significant medical staff expansions in both disciplines are planned in the near future.

Aware of the considerable overlap in the two specialities, as well as the clinical heterogeneity of the disorders involved, various steps have been taken to increase collaboration, particularly over the last decade. In Malta, which because of its size presents no problems as regards distance, very flexible appointment systems exist between the two specialty clinics for patient referral for joint consultations. In Italy, attempts have been made to organize out-patient clinics with a dermatologist and rheumatologist working together. This process, which is gradually transforming individual practice into a team approach rather than risking one side losing track of what is happening in the other, has allowed clinicians in either speciality to develop an insight into particular problems of the other one. This approach has been very helpful in enabling physicians to reach a diagnosis and plan therapy early in the course of an illness. Problems of disease classification, such as vasculitides and scleroderma, have led to reciprocal improvements in understanding and knowledge of these disorders. Restrictions in health care systems may jeopardize the effort, but this new-found cooperation will have a stronger voice in trying to obtain adequate funding since better 'value for money' will result. Many of us felt that this approach should be promoted on an international level, and that it was pertinent to organize a workshop where rheumatologists and dermatologists could discuss their problems together. The idea of promoting such a workshop initially seemed difficult. However, it eventually materialized with 'MaltaDerm '94—a Dialogue between Rheumatology and Dermatology', where both rheumatologists and dermatologists had a chance to cooperate both in the organization and active participation. MaltaDerm '94 was held in Malta in the historic Mediterranean Conference Centre, a 16th century building that was originally the hospital ('Sacra Infermeria') of the Knights of St John, and where the first chair of anatomy and surgery was established in Malta in 1676.
The success of this meeting suggested that a follow-up conference should be held along the same lines: RheumaDerm '97, which is planned to be held in Malta between 3 and 7 December 1997, will seek to take off where MaltaDerm '94 finished, and will explore further close links between the two specialities. We hope that the dialogue concepts will now pass from theory to practice. The international faculty feels that it should strengthen this common ground. In these days of accountability and quality assurance, there is little place for reduplication of effort and finance, and we suggest that not only will such efforts promote improved patient care, but they can also stimulate combined research efforts, both in the interests of patients and of society.